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NATIONAL HEALTH INSURANCE

PUBLIC HEARINGS
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES
NINETY-FOURTH CONGRESS
FIRST SESSION

NOVEMBER 5, 6, 7, 10, 11, 12, 13, 14, 17, 18, 19, 20;
DECEMBER 2, 3, 4, AND 5, 1975

PART 2 OF 3
(NOVEMBER 12, 13, 14, 17, 18, AND 19, 1975)

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NATIONAL HEALTH INSURANCE

WEDNESDAY, NOVEMBER 12, 1975

House of Representatives,
Subcommittee on Health,
Committee on Ways and Means,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to notice, in the committee hearing room, Longworth House Office Building, Hon. Dan Rostenkowski (chairman of the subcommittee) presiding.

Mr. Rostenkowski. The subcommittee will come to order.

I see that all our witnesses are in place. I want to welcome you to this morning's meeting. I know that we will have an informative discussion.

I would like to explain the format for today. We will begin from your right to left for individual presentations. Immediately after all the presentations have been made, we will give you an opportunity to have an interchange, which we hope is lively and informative.

After that we will go into the 5-minute questioning period, in which the members of the committee will participate. Mr. Delaney, if you would begin. Identify yourself, your organization, and proceed with your testimony.

PANEL CONSISTING OF W. GUY DELANEY, CHAIRMAN, ARKANSAS COMMITTEE FOR NATIONAL HEALTH INSURANCE; THOMAS G. DORRITY, M.D., PRESIDENT, ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS (TENNESSEE CHAPTER) AND MEMPHIS AND SHELBY COUNTY (TENNESSEE) MEDICAL SOCIETY; RENE I. JAHIEL, M.D., CHAIRPERSON, HEALTH CARE SUBCOMMITTEE, NEW YORK SCIENTISTS' COMMITTEE FOR PUBLIC INFORMATION; LLEWELLYN H. ROCKWELL, JR., EDITOR AND PRESIDENT, PRIVATE PRACTICE; AND SISTER REGINA FOPPE, TEXAS COMMITTEE FOR NATIONAL HEALTH SECURITY

STATEMENT OF W. GUY DELANEY

Summary

American medicine is everything it has always been and worse. It continues to be a self-serving multi-billion dollar industry that serves doctors, hospitals and insurance companies far better than it serves the public.

The time is long overdue for us to do something about cost, about quality, and about organization. Only the federal government is in a position to bring about the needed reform through a universal, comprehensive, and federally financed national health insurance.

Our committee believes that H.R. 21, the Health Security Act introduced by Representative James Corman and 100 cosponsors in the House of Representatives, will come closer to achieving the required results than any present legislation being considered.

A truly national health insurance would embody the following principles:

1. It should be universal so as to cover the entire population.
2. It should be comprehensive so as to cover the full range of health needs without cut-off dates, exclusions, coinsurance, and deductibles.
3. It should be federally financed and administered so as to bypass private health insurance companies.
4. It should give the consumer/patient a prominent voice in decisions affecting budgeting, organizations, manpower, and distribution of care.
5. It should provide for cost and quality control.

Any national health insurance that does not embody these principles will be just one more bitter disappointment in the area of medicine and politics that the American people will more and more see as betrayal.

Mr. DELANEY. Thank you, Mr. Chairman.

I am Guy Delaney. I am a Presbyterian minister and chairman of the Arkansas Committee for National Health Insurance.

Once again I am very happy to testify concerning the need for national health insurance and, specifically, the support of our organization for the Health Security Act. American medicine is everything it was when I testified before the Ways and Means Committee 4 years ago and worse.

We live in an era of unprecedented immorality. We are feeding a system whose foundation is built upon the tired, the poor, the huddled masses yearning to breathe free; a system that has an insatiable appetite for money that smells of greed; a system that is owned lock, stock, and barrel by doctors, insurance companies, and hospitals. The American people play two key roles, and two only, in the present evil-ridden system: they are sick and they pay the bills.

I am not here today to have my remarks recorded in the record. If the record made any difference, we would have had a universal, comprehensive, and federally financed national health insurance a decade ago. The words, once spoke, fall silent and become part of the record never again allowed to speak their bitter controversy about an industry that drains off over $100 billion from sick people and puts these dollars into the pockets of doctors, drug manufacturers, insurance companies, and nonprofit hospitals which take their profits in power, in salaries for administrators and medical staff, and in real estate, while leaving millions untreated and millions more poorly treated.

I do not speak, then, for the records. I am the voice of those who have never been heard in all of the years that national health insurance has been debated. I am the voice that falls on the deaf ears of a self-serving multi-billion-dollar industry. I am the voice of many of your constituents who are paying with their money and with their lives to support a system that is very poorly alined with their needs.

I hope you will hear the voice of the mother in rural Arkansas who had to hitchhike over 30 miles to the nearest hospital that would admit her son, who collapsed at school with a ruptured appendix. I hope you will hear the voice of the elderly across our State who are now paying more out-of-pocket cost for health care than they were the day medicare was enacted into law. I hope you will hear the voice of the poor in Arkansas who are refused treatment and badgered about their ability to pay. I hope you will hear the combined voices of half of the people who live in Arkansas that get no more than one-fourth of their health care needs met at any price.

Morbid episodes of mistreatment, maltreatment, nontreatment, profiteering, and lack of access to care are probably the only things in our society that are increasing faster than the soaring costs of health care. As a people we are in critical condition, and the time is long overdue for us to do something about cost; to do something about quality; to do something about organization.

In human terms we need a national health insurance that insures the American people rather than doctors, hospitals, and insurance companies. American medicine has fallen away from both morality and the concept of social responsibility. It is time for us to stop letting those with vested interest control who will get care, and how much it will cost. And to show that I am not alone in this belief, I would like to point out that the Cambridge survey of national health care completed in September 1975 showed that 57 percent of a scientifically selected national sample of people across the United States support the Health Security Act, or even stronger legislation.

Why the Health Security Act? I will attempt to answer this question with reference to the State of Arkansas.

First, it is universal in that it will cover the entire population. By definition a national health insurance would be universal. In that no other proposal in Congress is universal, we see vividly portrayed the way others borrow an idea and make something very different from it.

Second, the Health Security Act is comprehensive in that it covers the entire range of personal health care needs, including prevention and early detection of disease, care, treatment, and rehabilitation with no cutoff dates, no coinsurance, and no deductible.

This kind of coverage is very essential for a State like Arkansas. Our State's median income is only two-thirds the national average. Exclusions, cutoff dates, coinsurance, and deductibles are very definite barriers to those who seek access and treatment. It is a crucial barrier to the citizens of Arkansas.

Third, the Health Security Act provides for Federal financing through general revenues and social security. The patient now pays for his health care out-of-pocket, by taxes, and by insurance premiums. These methods of payment are inefficient, hopelessly confusing, totally unable to control costs, at the risk of drowning in their own paperwork, free from accountability, and full of incentives that work against the people who have to pay the bills.

What needs to happen, and the Health Security Act does this, is to get the private health insurance companies out of the picture. They have been failing the American public for three decades. Blue Cross-Blue Shield is a good example that insurance companies cannot be regulated or controlled. It is only a matter of time before the controlled end up controlling.

To illustrate this point we need only to look at the trustees of Arkansas Blue Cross-Blue Shield. Under Arkansas law these trustees must represent doctors, hospital administrators, and the general public. Already the votes of the health professionals constitute a majority of the board. But of greater concern is the startling fact that the public members of the board have business connections with Blue Cross-Blue Shield.

A Little Rock attorney, for instance, serves as a public trustee while his law firm is on retainer with Blue Cross-Blue Shield. In another case the president of the local bank holding Blue Cross-Blue Shield accounts serves as a representative of the general public.

Fourth, the Health Security Act will bring meaningful reform. Incentives will be applied to help correct the maldistribution of health manpower. Quality controls will come into play that will help protect the public from malpractice. Resources will be made available for a more rational approach to care. Sacred cows—solo practice and fee for service—will be sacrificed on the altar of justice and mercy.

Arkansas needs the kind of reform that only the Health Security Act can provide. One county in Arkansas has 40 percent of the State's physicians. Hospitals continue to be built in Little Rock when an increase in beds is highly questionable. Outside of Little Rock and Pulaski County many areas of Arkansas are medical wastelands.

And so today I appeal to you to write legislation using as a model the Health Security Act, H.R. 21, that will help give the sick of our Nation a chance to get well. Any national health insurance legislation that does not embody universal coverage, comprehensive benefits, Federal financing, cost and quality controls, and consumer participation would perhaps be an unintentional but nevertheless a cruel fraud for all Americans and especially for the people of Arkansas.

Our hope is that you will rise to the expectations and the needs of the American people.

Thank you, Mr. Chairman.

[The following was received for the record:]

BLUE CROSS BLUE SHIELD OF ARKANSAS,
Little Rock, Ark., December 2, 1975.

HON. AL ULLMAN,
Chairman, House Ways and Means Committee, Rayburn House Office Building, Washington, D.C.

DEAR CHAIRMAN ULLMAN: I have had occasion to review the November 12, 1975 testimony of W. Guy Delaney before the Subcommittee on Health of the House Ways and Means Committee on behalf of the Arkansas Committee for National Health Insurance. On page four of Reverend Delaney's testimony, he makes reference to Arkansas Blue Cross and Blue Shield. The statement reads that "Already the votes of the health professionals constitute a majority of the board".

Since March of 1975 our Board of Trustees has been composed of six physicians, six hospital administrators and thirteen public members. This is clearly a public majority. Hence, Reverend Delaney's testimony is grossly inaccurate, and I respectfully request that the record take note of this erroneous and misleading information.

Respectfully,

GEORGE K. MITCHELL, M.D.,
President and Chief Executive Officer.

Mr. ROSTENKOWSKI. Thank you, Mr. Delaney.

Dr. Dorrity?

STATEMENT OF THOMAS G. DORRITY, M.D.

Dr. DORRITY. I am Thomas G. Dorrity, a practicing surgeon in Memphis, Tenn. I am speaking for the Tennessee chapter of the Association of American Physicians & Surgeons, and the Memphis-Shelby County Medical Society. In addition to being a surgeon, I have a degree in law.

I was shocked the other day—and I am sure you are going to be shocked, and most Americans will be shocked, too, when they find out—I was shocked to find conclusive evidence that the Federal bureaucracy believes that Congress has given it the power to cancel the Constitution of the United States.

Now let me repeat that. I know you want to understand what I said. I was shocked the other day to find out that the Federal bureaucracy—specifically the Department of Health, Education, and Welfare and the Justice Department—believe Congress has given them the power to cancel the Constitution.

I have in my hand a copy of a brief filed with the Supreme Court by the Justice Department on behalf of HEW. Here is what that brief says:

> Patients whose medical care is provided by public funds have no constitutional right to obtain that care from a physician of their choice.

That brief was filed in connection with the lawsuit brought by the Association of American Physicians & Surgeons challenging the constitutionality of an amendment to the medicare-medicaid law known as the PSRO law.

Frankly I am alarmed that the Federal bureaucracy has devised this scheme for depriving citizens of their constitutional rights—a scheme already set in motion. The scheme, simply stated, is this: Deprive citizens of their earnings by taxation, which then become public funds—for example, social security taxes. Use that money to provide citizens medical care on terms dictated by the bureaucracy—for example, medicare and medicaid. When the citizen insists on exercising freedom to choose his own physician, the bureaucracy says "no."

If the patient or his physician takes his denial to court, the bureaucracy argues that the citizen whose medical care is paid, in part, from public funds can't claim infringement of a constitutional right to freedom of choice because he doesn't have that right.

Furthermore, HEW and the Justice Department contend in their brief that this same citizen, because his care is paid from public funds, has no right to the medical care his doctor judges necessary or appropriate. I will bet you didn't know that when Government pays, constitutional rights disappear.

I will bet a lot of Members of Congress thought that sections 1801 and 1802 of the medicare law guaranteed medicare patients freedom of choice of their doctor and hospital, and prohibited the Federal bureaucrats from interfering in the practice of medicine. At least that is what the medicare law says.

That is what the AAPS lawsuit is all about. Our association believes that the PSRO law not only invades the constitutional rights of patients and doctors, it violates the clear prohibitions contains in sections 1801 and 1802 of the medicare-medicaid law itself.

When legislation which became the medicare-medicaid law was drafted and presented to the Congress, the public was assured that the government would not interfere in the practice of medicine, or in the operation of hospitals, and would not deny patients freedom of choice of doctors and hospitals.

In fact, Mr. Anthony Celebrezze, then Secretary of HEW, specifically said in 1963 to the House Ways and Means Committee:

> Mr. Chairman, there are certain arguments and allegations that have been made concerning the hospital insurance proposal that I would like to respond to. Allegation: The program would interfere with doctor-patient relationships, and would tend to lower the quality of medical care.
>
> Of course this is not true. In the first place, the cost of services of the individual's own physician is not covered under the bill, so there could be no direct effect on relationship between the doctor and the patient.

Physician services were added to the bill after this, but before passage. The HEW Secretary went on to say:

> There would be no interference with established practices for providing health care; *freedom of choice of physicians* and facilities *would not be affected.* [Emphasis added.]

In the AAPS case the defendent Federal Government has attempted to dictate to doctors how they diagnose, treat, and care for patients. In fact, they refer to it in the vernacular as "looking over the doctor's shoulder." AAPS in its suit pointed out:

> The legislation in question signals the first extension of Federal authority to the control of the substantive aspects of medical practice through the imposition of prior and concurrent restraints upon physicians' medical judgment and practices in treating their patients.
>
> Enacted to control expenditures under the Federal Medicare and Medicaid programs, the law represents a radical departure from traditional concepts of case-by-case, after-the-fact professional peer review.

The Government seeks to avoid the clear weight of opinion of the Supreme Court which has said that a law which seeks to subordinate the attending physician's judgment to that of two other physicians infringes upon the fundamental right of the physician to administer necessary help to his patient. The court also said that the 1st, 9th, and 14th amendments protect the right of a physician, as well as every other citizen, to pursue his chosen profession free from unnecessary interference from the State.

Another frightening aspect of this case is that when Federal Government officials try to entice the public into agreeing to a multibillion-dollar bureaucratic medical program, they loudly trumpet that health care is a right. However, after the program is put into effect, they proclaim that it isn't a right after all—that the patient has no choice, and must accept dictation and control from the Federal bureaucracy, not only for himself, but also for his doctor.

The virtually endless parade of witnesses overwhelmingly weighed on the side of individuals and groups subsidized by Government continues to testify before this panel and other panels of Congress in favor of various schemes of compulsory politicalized medicine, falsely labeled national health insurance.

Unanimous quests of witnesses is another mammoth Federal spending program that will greatly enlarge the power of the Federal bureaucracy, while simultaneously adding to the power of labor leaders who exercise inordinate control over the bureaucracy, and who also seek more power through unionization of more Federal employees.

Still another aspect of this problem with which citizens, and you as their representatives, should be aware is that HEW experts said before medicare was enacted into law that medicare hospitalization alone would only cost $900 million in the first full year of operation.

Yet it actually cost for the first full year of operation $2.7 billion, or 300 percent more than was estimated.

The bureaucrats said it would cost $1.4 billion the first year, and actually it cost four times that much. And in the 10th year it is costing at least 800 percent of what they said it would cost.

Nevertheless, with ths unconscionable record which has undoubtedly contributed to inflation and the robbing of poor people and people on pensions and the older people, Congress is flirting with the idea of establishing another huge bureaucracy to provide national health insurance for everyone.

One proposal is to insure everyone against catastrophic illness at an estimated cost of—the sky is the limit. You can get almost any estimate from every bureaucrat you talk to. The records of this committee show that Secretary Weinberger in April 1974 testified that the provisions of the Long-Ribicoff catastrophic coverage bill would decrease private spending $3.9 billion in fiscal 1975 to $125.8 billion of what he referred to as an induced cost increase of $4.4 billion.

The same kind of bureaucrats estimated the cost of medicare are the ones who make these estimates. At best the Long-Ribicoff bill on catastrophic insurance would probably cost at least $4 billion estimated by HEW times three, to allow for the similar understatement that has been made on previous occasions for medicare, for example.

However, we note that Mr. Leonard Woodcock, spokesman for the Committee of 100, and his long-time colleagues, have been working for years for complete compulsory medicine and have told this committee they do not intend to stop until it is accomplished. If you haven't done so, you should read the HEW pamphlet put out in 1969 called "Medicare from Idea to Law," in which the bureaucrats brag about how they have manipulated Congress and pushed through the medicare law.

From the chronology set forth in this document it is quite obvious that it is patterned after socialized medical schemes in effect now in Germany and Russia.

The professional apologists for the Department of HEW, who wrote the book on PSRO, Arthur D. Little Co., have recently come up with a study which the UPI reports as follows:

> A government study says that perhaps for less than $2 billion a year the National Health Insurance Plan could have protected all Americans under 65 from the financial ravages of catastrophic illness or injury.

Any legislator which acts upon this self-serving deceptive statement of the Federal bureaucracy should be kept home by his constituents in the next election. Obviously this is a fraud and any responsible legislator can get information to show that it is fraudulent very easily.

The catastrophe that every citizen in America has to worry about most is the fact that the Federal Government is spending all of us into bankruptcy. For every dollar a citizen saved in 1940, the Federal Government has stolen over 75 cents of it and for every dollar that was saved in 1967, the Government has stolen one-third of this through inflation.

If the Congress passes any more spending legislation, such as now being proposed for so-called national health insurance, it is an absolute certainty that bureaucracy will steal more billions from the working citizens of this country through destroying the value of their savings and earnings.

Thank you.

Mr. ROSTENKOWSKI. Thank you, Dr. Dorrity.

Sister Foppe?

STATEMENT OF SISTER REGINA FOPPE

Sister FOPPE. Mr. Chairman and members of the committee, my name is Sister Regina Foppe. I am the director of social action services for the Diocese of Amarillo with residency at Lubbock in District 19 of the State of Texas. I am representing the Texas Committee for National Health Security.

I thank you for inviting me to share with you my concern, especially for those who do not as yet share equally in all areas of general welfare. I would like to address one aspect of it, the matter of health care.

My immediate concerns are the people living in the 46 counties of the Panhandle and South Plains regions. Well aware that no chain can be stronger than its weakest link, my concern also encompasses all the people of Texas and the Nation. Disease, epidemics, and illness know no boundaries. The health of a total people is the hallmark of a Nation.

The Census of 1970 shows Texas having a population of 11,196,730. Using a conservative estimate of 150 percent of poverty level, 2,832,773 persons are in this group. Allowing 50 percent of the elderly, age 65 and over, 171,874 are without any type of health insurance, including medicare or medicaid, either through ignorance or denial. To this number add the 316,194 persons under age 18 on AFDC receiving medicaid, then allowing for an additional adult in the same household—household of four—receiving the same benefits, which is not always the case, another 105,398 can be added, totaling 593,466.

In the 150 percent of poverty levels there would remain 2,239,307 people in Texas without any health insurance coverage whatsoever. For the most part these are the low-income blue-collar workers, often with large families, who struggle to provide for our needs and services, and the elderly who have struggled to build our State and our Nation.

Let me look at this more specifically for west Texas through a recent survey.

Through the courtesy of the West Texas Health Systems and James E. Archer & Associates, both centered at Lubbock, the pastors and parishioners of Our Lady of Grace, St. Elizabeth, St. Joseph's, St. Patrick's Churches with urban populations in Lubbock; St. Michael's, Ralls and San Jose, Crosbyton, with rural populations and Sacred Heart, Plainview with urban-rural population we took a "Poll on Health Insurance for the Family" on Sunday, Oct. 26, 1975, and had it computerized.

The polls for Our Lady of Grace, St. Michael's, and San Jose were taken following the worship services. We, therefore, had a 100 percent family participation of all the worship services. St. Joseph and Sacred Heart parishes sent the forms home and had family returns of approximately 20 percent. St. Elizabeth, a middle- to upper-income parish, had less than a 1 percent (0.3 percent) return, this latter parish had excellent coverage for its families.

In all parishes, with the exception of St. Elizabeth's, the membership is 99 percent or more Spanish surnamed. These parishes were used primarily because of their accessibility and their willingness to cooperate in the poll in the limited time available to gather this information. St. Patrick's distributed forms in a parish society and a small number returned them by mail. Tabulations show that the higher the earnings in relation to size of family, the better the coverage. The families polled are typical of the situation of urban-rural west Texas. They demonstrate the need of those within the 150 percent of income of the poverty level. Of the 694 families, 330 families (47.5 percent) came within the 150 percent of the income poverty level with a membership of 1,828 (53.9 percent).

Many persons in west Texas today are denied preventive health care services because of the lack of ability to pay. To my knowledge there are no county hospitals, and most of the communities have no free clinics. A number of small communities are without doctors. This has created serious problems and when those least able to pay must finally be hospitalized, their hospital stays are longer and more costly, creating a complex monster which ruins families.

Good credit ratings are destroyed for the next 7 years, in most instances a vicious cycle of poverty is created, and the economic base of the family is totally destroyed. Most low-income blue-collar workers do not understand or use laws pertaining to the declaration of bankruptcy, so they lose their homes, home furnishings, and car as they go into repossession. Motivation is impaired and finally drives them to enter the welfare rolls.

Illness, which is no respecter of persons, can strike any of us. It should not deprive any person of his or her dignity. Yet the fears and worries that threaten many in our society today do just that and further complicate the problems of our society.

Our present health care system is centered primarily on the ability to pay, and excludes 35 million persons in our country who scarcely have the means to meet the basic costs of food and shelter.

Since we have the know-how to pinpoint landing on the moon, we also must have the know-how of how to build a healthy society. To succeed we need the motivation, becoming convinced that human beings must be given priority over material accomplishments.

Today we need a health care system that provides equitable health care based on need to every person in our country. It should be administered through a single trust fund with all health care statements incurred sent directly to them to eliminate duplication of forms and time. The patient should retain his right to freely choose his doctor and the hospital. Health care must have a cost control built into it. The trust fund should be administered by a board of directors with equal membership drawn from the medical profession and from the American consumers.

In the legislation before the present Congress, the Health Security Act (H.R. 21, S. 3) is the only bill that subscribes to health care as a right based on need, which, if passed, can be implemented within a reasonable period of time. May I recommend that Congress seriously consider to enact this bill in the Bicentennial Year.

Should another Congress need to convene before its passage, may I recommend that a bill similar in all aspects of the present Health Security Act be passed to assure "health care as a right to every American resident" in the near future. In principle we, the American citizens, subscribe to it in the Preamble of our Constitution ". . . to form a more perfect Union [by] establish[ing] Justice . . . [and] promot[ing] the general Welfare" in order to share "liberty and justice" with all. Let our words move into action.

Thank you.

[The prepared statement and appendixes follow:]

STATEMENT OF SISTER REGINA FOPPE, TEXAS COMMITTEE FOR HEALTH SECURITY

Mr. Chairman and members of the committee, my name is Sister Regina Foppe. I am the Director of Social Action Services for the Diocese of Amarillo with residency at Lubbock in District 19 of the State of Texas. I am representing the Texas Committee for National Health Security. I thank you for inviting me to share with you my concern, especially for those who do not as yet share equally in all areas of general welfare. I would like to address one aspect of it, the matter of health care. My immediate concern are the people living in the 46 counties of the Panhandle and South Plains Regions. Well aware that no chain can be stronger than its weakest link, my concern also encompasses all the people of Texas and of the nation. Disease, epidemics, and illness know no boundaries. The health of a total people is the "hallmark" of a nation.

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Poverty and non-poverty in this survey are based on the "CSA New Income Poverty Guidelines" (revised) published in the *Federal Register*, Vol. 40, No. 62, dated March 31, 1975.

The survey included 694 families with 3,391 persons. Of these 665 cases were valid throughout the questions, 29 left blank some questions, and of the latter 10 were invalid. Head of household listed Males 89.2 percent and Females 10.8 percent. The largest group of families were listed in the 3, 4, or 5 members.

As you will note in Appendix A (attached), the CSA Poverty Guidlines are Extremely meager to live with in our present society, when this income is not supplemented in some manner. In the case of most of the families polled with a 150 percent or less poverty income, it is not supplemented, because the complexity of the bureaucracies. The families have a right to maintain their dignity and not subject themselves to de-humanizing processes.

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[1] St. Patrick's distributed forms in a parish society and a small number returned them by mail.

Appendix B shows the form used. It would have been helpful if two further questions had been included:

1. Members age 65 and over.
2. (*a*) Number of members in family who are handicapped. (*b*) Age of handicapped member(s).

The survey tabulated 694 families with a membership of 3,391, allowing 4.8 members per family. [Number of Individuals, Nov. 11, 1975, page 2.]

They were tabulated into the following income groups:

Within poverty	918
101 to 125 percent poverty	407
126 to 150 percent poverty	388
151 to 200 percent poverty	616
Over 200 percent poverty	947
Unknown (possibly meager education and/or language handicap very likely in poverty)	115
Total	3, 391

[Number of Individuals, Percent of Poverty Status, Nov. 11, 1975, page 3.]

This lists that of 694 families, 330 families (47.5 percent) with a membership of 1,776 (52.5 percent) with an income level between poverty and 150 percent poverty. [Number of Families, Percent of Poverty Status, Nov. 11, 1975, page 18; Number of Individuals, Percent of Poverty Status, Nov. 11, 1975, page 3.]

A further breakdown: of the 3,391, those over age 18 numbered 1,504. Of the latter 713 (46.7 percent) live within a family that have an income level between poverty and 150 percent of poverty. [Numbers of Adults, Percent of Poverty Status, Nov. 8, 1975, page 6.]

Children ages 6 to 18 number 1,406. Of this number, 845 (60.1 percent) live within a family that have an income level between poverty and 150 percent of poverty. [Numbers of Adults, Percent of Poverty Status, Nov. 8, 1975, page 9.]

Preschool children to age six number 429. Of this number, 218 (50.8 percent) live within a family that have an income level between poverty and 150 percent of poverty. [Numbers of Preschool, Percent of Poverty Status, Nov. 8, 1975, page 12.]

Of the 3,391 persons polled the following indicated they had no health insurance:

	Members polled	Percent	Members no insurance	Members minimum [1] maximum insurance
Our Lady of Grace Lubbock, urban	1, 859	54. 8	661	1, 198
St. Elizabeth's Lubbock, urban	35	1. 0	0	35
St. Joseph's Lubbock, urban	639	18. 8	288	351
St. Patrick's Lubbock, urban	70	2. 1	20	50
San Jose Crosbyton, rural	243	7. 2	143	[2] 100
St. Michael's Ralls, rural	403	11. 9	219	[2] 184
Sacred Heart Plainview, rural	91	2. 7	35	[2] 56
Sacred Heart Plainview, urban	51	1. 5	37	14
Total	3, 391	100. 0	1, 403	1, 988

[1] Minimum and maximum range. One marked: "Payments begin after 30 days of hospitalization. Others remarked: Coverage ranged from 10 to 80 percent when written in the margins. Families marking insured members, it was assumed that all the members were insured.

[2] A number of heads of households marked: Only in case of accident.

Note: Numbers of individuals, where family attends mass, Nov. 8, 1975, p. 2. Total persons indicating insurance, Nov. 8, 1975, p. 14.

Under "Who Pays for Other Members Insurance". On page 17 of November 7, 1975, it states 42.5 percent of other members in households have no coverage. On page 10 it states 33.6 percent of Heads of Household have no coverage.

In two and one-half times as many cases employers participate in insuring the second working adult in the household who may be listed age 18 and over. About one-third of the families had a second working adult. When the second working adult has insurance coverage paid by his/her worker, this will change the figures of pages 11 and 17 to read:

"Head and second adult employee (wife) paid by employer 42.5 percent by Head 32.3 percent, other (Medicare and Medicaid) 3.4 percent, Employer and Head 21.8 percent" [November 7, 1975, pages 10–18.]

	Persons
Medicare—part A and B coverage	18
Medicare—part A only	29
Medicaid[1]—old age assistance	12
Total	[2]59
Medical—AFDC	[3]12

[1] Many of the elderly who worked in agriculture had no health insurance nor social security: In many instances their married children, in spite of great hardship are attempting to care for their needs.

[2] November 7, 1975 pages 22–24.

[3] November 7, 1975, page 25.

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In the legislation before the present Congress, *The Health Security Act*, (H.R. 21, S. 3) is the only bill that subscribes to "Health Care As a Right Based On Need" which if passed, can be implemented within a reasonable period of time. May I recommend that Congress seriously consider to enact this bill in the Bi-Centennial Year. Should another Congress need to convene before its passage, may I recommend that a bill similar in all aspects of the present *Health Security Act* be passed to assure "Health Care as a Right to every American Resident" in the near future. In Principle we, the American citizens, subscribe to it in the Preamble of our Constitution ". . . to form a more perfect Union [by] establish[ing] Justice . . . [and] promot[ing] the general Welfare" in order to share "liberty and justice" with all. Let our words move into action.

Appendix A

CSA New Income Poverty Guidelines effective April 30, 1975. Revised Guidelines published in the Federal Register, Vol. 40, No. 62, dated March 31, 1975.

Family size	Nonfarm family	Farm family
1	$2,590	$2,200
2	3,410	2,900
3	4,230	3,600
4	5,050	4,300
5	5,870	5,000
6	6,690	5,700
7	7,510	6,400
For each additional member add	820	700

APPENDIX B

Poll On Health Insurance For the Family - October 1975

Please fill out completely:

1. Head of household: Male___ Female___

2. Total number living in home______

3. Number in home over age 18____age 6 to 18 _____preschool______

4. Gross earnings of head of household____week: $______________
____2 wk:
____month:

5. Gross earnings of other working members over age 18 in home ____week: $______________
____2 wk:
____month:

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6. Does Head of Household have health and hospital insurance? ___ Yes ___ No

Who pays premium? Employer or company_____Head_____Other_____

If answer to No. 6 is yes, what does it cover?

Doctor Visits: All___Part___None___Lab & X-rays: All___Part___None___

Hospital: All___Part___None___Medical Prescriptions: All___Part___None___

7. Does spouse and children have health and hospital insurance ___ Yes ___ No

If yes, who pays for it?______If Head of Household pays what is monthly cost? $______ Does it cover?

Doctor Visits: All___Part___None___Lab & X-rays: All___Part___None___

Hospital: All___Part___None___Medical Prescriptions: All___Part___None___

8. Please check if any one in home is covered by:

Medicare: Part A___________ Part B__________

Medicaid: through Old Age Assistance_____________through AFDC_________

Our Lady of Grace, Lubbock, Texas October 26, 1975
Please do not write below this line. Thank you. Sister Regina Foppe

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1. M___F___ 2 and 3. Family Size_____ 4 and 5. Gross$______wk___2wk___mo___

6. Coverage H: All___Part___None___ 7. Coverage S & Ch: All___Part___None___

8. Medicare: Part A_____ B_____ Medicaid_______________

Mr. Rostenkowski. Thank you very much, Sister Foppe.

Mr. Rockwell.

STATEMENT OF LLEWELLYN H. ROCKWELL, JR.

Mr. Rockwell. Mr. Chairman and members of the subcommittee, thank you for the opportunity to testify before you today.

I am Llewellyn H. Rockwell, Jr. I'm editor and president of Private Practice, a journal of socioeconomic medicine published in Oklahoma City. Private Practice, which has a circulation of 175,000, is the official publication of the Congress of County Medical Societies.

As a layman I would like to discuss the effects comprehensive national health insurance will have on patients.

The Department of Health, Education, and Welfare estimates that the Kennedy-Corman bill will cost the American taxpayers $113 billion the first year. Given HEW's past performance with this kind of estimate—for example, even deducting for inflation, medicare is far more expensive today than HEW said it would be—I believe the eventual cost of such a program would be a minimum of $300 billion.

The economists tell us that medical care is an economic good. That is, it is both scarce—there is less than an unlimited supply—and it is in demand. An economic good must have both qualities. Air is in demand, but it isn't scarce. Smallpox is scarce, but it is not in demand.

In a free market the mechanism of price tends to bring supply and demand for economic goods into equilibrium, so there is neither a surplus nor a shortage. But when government intervenes to set prices, distortions result.

In the 1950's the Department of Agriculture set the price it would pay for wheat substantially higher than the market price. The result: huge surpluses. Recently the Federal Energy Administration set the price of gasoline lower than the market price. The result: shortages and long lines at gas stations.

The Health Security Act, by setting the price of medical care at zero, will drastically increase demand. When demand increases, costs increase. And with the price to the user set at zero, demand will tend toward the infinite. It is this demand that will cause the cost of national health insurance to skyrocket.

But the American Government does not have infinite resources. And Congress and the American people will not accept another $300 billion in taxes and inflation. With the price set at zero, there is only one way to hold down demand and, therefore, costs: bureaucratic rationing. Government is not capable of delivering universal, free medical care. Despite the promise, the reality will be ugly.

Bureaucrats will decide when patients can and cannot go into the hospital. They will decide what drugs will be prescribed, and what treatments will be allowed.

As a layman, if I am sick, I want my doctor deciding, in consultation with me, what is best for me, whether I need to go into the hospital, what course of treatment I need. I pay him, and he is responsible to me. Under comprehensive national health insurance the doctor would be paid by the Government, and his loyalty would eventually shift, although slowly, to the Government and away from the patient. We see this already in the VA and military medicine.

And with the greatly increased demand flooding doctors' offices—the Rand Corp. estimated an immediate 75-percent increase under comprehensive national health insurance—the truly sick will get less medical attention than they do now. The amount of medical care will not be increased, but the sick will have to share it with the hypochondriacs, the worried-well, the bored, the lonely, the neurotic, to a far greater extent than is now the case. Because it will be free.

Some reject the specter of rationing as unnecessary under national health insurance. But we can see its effects already, in a small way, under medicare and medicaid.

HEW's attempt, under the maximum allowable cost regulations, to have medicare and medicaid patients use only the cheapest drugs, is one example. The attempted imposition of preadmission certification—forcing a doctor to get permission from a bureaucrat before admitting a patient to the hospital—is another, as was utilization review, now temporarily sidetracked.

PSRO is an open attempt to ration care by controlling hospital admissions, stays, and methods of treatment. PSRO also gives HEW access to medicare and medicaid patients' most intimate medical records. Under NHI the Federal Government will control the medical records of all Americans. Has someone had VD, been a drug addict, attempted suicide, had an illegitimate child? All this will be available to HEW.

Care has also been rationed under medicare and medicaid by imposing unreasonable paperwork on patients and doctors, to slow down the rate of reimbursement. And reimbursement is arbitrarily denied in many cases to cut costs. In a recent article in the Journal of the American Medical Association, Dr. Donald F. Dalessio tells of an 85-year-old man who died in the hospital while under treatment for a terminal illness.

Months after his death medicare refused reimbursement, saying that his hospital stay was "not medically necessary." Every doctor can tell many stories like this. None of this is accidental. It is a deliberate attempt to hold down costs that would otherwise go out of control. It is but a taste of what will happen under NHI.

But there is an even better example of what governmental medicine means to patients and a nation. Since 1948 Great Britain has been providing free-at-the-time medical care. After drawing for years on the endurance of patients and the good will of doctors, nurses, and other professionals, the national health service is collapsing. It has been a laboratory of nationalized medicine, and last summer I went to England to study it with the board of the Congress of County Medical Societies and a number of Congressmen, including some on this subcommittee.

The National Health Service Act was passed by Britain's Labor-dominated Parliament in 1946. In July 1948 Minister of Health Aneurin Bevan's dream, the national health service, came into being. It was, said one supporter, the "most unsordid act in history." Be that as it may, it was assuredly one of the most naive.

The NHS would save Britain money, Mr. Bevan assured the nation, because once medical care was free, everyone's health would improve. There would be fewer sick days taken, and everyone would have a longer working life. And as the backlog of untreated illness diminished, the NHS budget would fall. In 1948 that budget was 148 million pounds; today it is 4.5 billion pounds, a figure the present Labor government promises to increase at 10 percent a year, while it is inflating the money supply at a rate exceeding 26 percent.

Dr. David Owen, Minister of State for Health, was uncommonly candid when addressing a meeting of community health officials shortly before we arrived:

> The Health Service is a rationed service. There will never be a government or a country that has enough resources to meet all the demands any nation will make on a National Health Service.

This is the reality. Not healthier people at a cheaper price, as Mr. Bevan predicted, but a system of medical care full of monstrous inequities for patients and doctors.

Mike Wallace, in a laudatory NHS report on CBS' "Sixty Minutes," told of a woman who needed open-heart surgery and got it immediately, with no expense but the busfare from home.

Far more typical of the NHS is the woman from Wales whom Sir Alan Marre, the new NHS ombudsman, describes in his June 1975 report: After a long wait—over 6 months—she was called into the hospital for open-heart surgery on January 20, 1973. On January 30, 1 day before she was to be operated on, the surgery was canceled, and she was discharged because of crowding on the surgical schedule. And 4½ months later she was readmitted, but was again discharged 4 days later. She was to enter the hospital again on June 27, but on June 26, she was notified by telephone that her operation had been canceled. She died 2 days later.

The NHS ombudsman also reported on a man needing surgery as a result of an automobile accident. Even though his pain prevented him from working, he had to wait more than 11 months.

A GP referred a woman patient to the hospital for a biopsy of a lump in her breast. It was 8 weeks before the hospital got around to it, and afterward she was discharged still groggy from the anesthesia. When she returned to have the stitches removed, the biopsy results were "not available." Some days later her GP was notified the lump was malignant. He then referred her back to the hospital for surgery, but she was informed that no firm date could be given her for admission.

An elderly woman needed a hip replacement. She was told in June 1972 that she could be admitted in 9 months to a year. Two years later she was still 32d on the list. Another older lady was placed on the waiting list for hip replacement in October 1971. As of January 1975, 1 year after her admission had been classified as "urgent," she was still waiting.

An orthopedic surgeon at St. Mary's Hospital, Paddington, told me that any older person needing a hip replacement will probably die before getting to the top of the list. In London, he said, it takes an average of 9 months to get an appointment with an orthopedist. In other specialties it is not much better, with waiting lists for hospital admission ranging from 1 to 2 weeks for acute cases, to 2 to 3 years for hernias and other non-life-threatening but painful problems.

Dr. Christian Loehry, chairman of the medical staffs at Poole Hospital and Royal Victoria Hospital, both in Bournemouth, said that crowding has led to patients who might otherwise have lived dying at home before they can be admitted; patients dying in the emergency rooms after waiting hours for a bed; cancer patients waiting up to 6 weeks for treatment while their tumors spread; and emergency cases smuggled into the beds of patients being operated on, so when they return from surgery there is no room for them. Doctors call this "musical beds."

Overutilization caused by the zero price not only packs the surgical waiting lists—some 700,000 people are on them by the British Government's own figures—it makes hospital stays longer. The average British patient will spend 11 days in the hospital for an uncomplicated hernia. Some hospitals average 21 days. For an uncomplicated cholecystectomy, the average is 10 days, with some hospitals averaging over 15. We have the same problem with our Government hospitals. In our private hospitals, the stays for these operations average 4 to 6 days.

Orthopedia surgeon Anthony Partridge told us.

> When the patient eventually arrives in hospital for surgical treatment, he must sign a consent form before the operation can take place which says, "No assurance has been given to me that the operation will be performed by any particular practitioner." But the discerning patient wants to make sure that he has the surgeon of his choice—the patient is scared stiff of being operated on by some doctor in training. Even the politicians who want to get rid of private practice for the rest of us use it themselves when it is a question of the knife going into them.

Britain has such a high proportion of foreign physicians because of the "brain drain," which works both ways. British doctors emigrate to the United States and South Africa, and England is a big improvement over Sri Lanka. And the process is accelerating. A resident at London's Charing Cross Hospital told me that out of the 25 doctors he qualified with, 10 have already left, with more on the way.

Twice-a-year examinations are given in London to qualify British doctors to practice in the United States. In 1972, 404 doctors took the test; in 1973, 838; in 1974, 1,019. And 2,517 English doctors took the exams this January with a similar number in July. An advertisement in the British Medical Journal for an English doctor to practice in Saudi Arabia drew 300 applications.

But the quality of the doctors immigrating to Britain is much lower than those leaving. Just recently the Government started giving tests to foreign physicians wishing to join the NHS. Of the first two groups, 60 and 62 percent failed the tests in language and clinical skills. Yet thousands of deficient foreign doctors already fill the NHS.

England's hospitals are in no better shape. Even the showplace Charing Cross is crowded. But conditions in the average hospital—many built in the 19th century and converted from workhouses—are squalid: Dirty, overcrowded, minimal fire precautions, outdated equipment. A Congressman told of one, built in 1830, where "they were preparing food for 400 to 500 patients in a room so filthy it was unbelievable."

A London Daily Mirror story, which announced that the NHS is "gravely ill," told of patients holding cockroach races in grimy corridors.

In the 27 years preceding the NHS—which includes World War II—far more hospital beds were provided than in the 27 years since 1948. "Building a new hospital (under the NHS) in this country," said Sir Keith Joseph, who used to be in charge of the NHS, "is like building a cathedral. It takes generations. I remember going to a hospital once to open it. I really felt inclined to say, as I patted it open, so to speak, lovely, but you have been 20 years in the designing and building. It was totally obsolete."

"Half of the hospitals in the country should be closed," one high-level NHS employee told me. But even at the better ones, food is atrocious and ancillary services are almost impossible to get outside normal working hours. Doctors told me they could usually get pathology and radiology services between 9 and 5, 5 days a week, but sometimes not even then. At night and on weekends it was out of the question.

As bad as acute care is, chronic care is even worse. "Our Health Service," said Sir Keith Joseph, "is totally overwhelmed by chronic conditions . . . By putting on the public purse centrally the care of the schizophrenic, the senile, the arthritic, the incontinent, by removing from the local community the responsibility for caring for their own totally dependent patients, we have provided appalling service. We have turned off the tap of charity; we have turned off the tap of local pride; we have turned off domestic and family care.

"All of these used to look after the least glamorous of the health requirements, which have now been thrown onto the shoulders of central government and the taxpayer in this country. The result is squalor. The normal run of hospitals for the elderly . . . and mentally handicapped . . . and mentally ill . . . are medieval."

General practitioners normally have over 3,000 patients on their lists, to whom they contract to give unlimited service. "It is quite easy to manage 3,000 patients," said former GP Dr. Anthony Partridge, "acting as a sort of clearinghouse, but it is quite impossible to doctor them, to listen to them and to reassure them, as we were taught to do as students . . . . The doctor is paid on quantity, not quality.

> A proper first examination should take about 45 minutes, but in the NHS four minutes is the more usual pattern, and unlucky patients do not get even that, but are given a prescription following a telephone conversation with the receptionist . . .

Preventive medicine is nonexistent. Physical examinations are unknown, and under the NHS women can get pap smears only once every 5 years.

One Congressman asked an airline representative, an attractive young woman but for some facial scars, what she thought of the NHS.

> It's a good system. We get all our medical care free, you know. No worry about expense.
>
> No complaints at all?
>
> It is rather slow. I had to wait eight years for an appointment with a dermatologist about my face. When I saw him, he said I would have to wait a year for treatment. But it is free.

This is the system some would impose on America.

Our system of medical care, while far from perfect, is the best in the world. Many of the problems it does have are caused by governmental intervention or inflation, also caused by Government. More Government will only exacerbate the problems. Total Government control under comprehensive national health insurance will destroy quality medical care in America.

Each of the pieces of legislation before you differs with regard to the extent of rationing it will make necessary, and the manner in which governmental control and supervision will be imposed. Each is similar, however, in its acceptance of the basic premise that there is a crisis in American medical care and that a governmental program is necessary to correct it.

But the crisis seems to be largely media and politically created. For example, when the Bureau of Social Sciences Research polled the residents of the Washington, D.C., area, including many low-income people, the results showed 49 percent of the people very satisfied with their medical care and 37 percent pretty satisfied. That is a whopping 86 percent, with only 3 percent not at all satisfied.

Yet thanks to the media and political blitz, 75 percent of those interviewed said they believe there is a crisis in medical care. It is this media-created crisis, at a time when more Americans are receiving better care than at any time in our history, that has created demand for national health insurance.

I hope that this subcommittee and the Congress as a whole will reject this demand. As a layman and a potential patient I have a stake in a system that puts the control of my medical care in my hands and my doctor's. So does every American.

Thank you.

Mr. Rostenkowski. Thank you, Mr. Rockwell.

Dr. Jahiel?

STATEMENT OF RENE I. JAHIEL, M.D.

Dr. Jahiel. My name is Rene Jahiel. I am a physician and a professor of preventive medicine at New York University's School of Medicine, but I appear today as chairman of the Health Care Subcommittee of the New York Scientists' Committee for Public Information, which I shall refer to as the Scientists' Committee.

The Scientists' Committee is a 17-year-old organization of scientists, physicians, engineers, and other experts, who analyze technical problems to help the public to be well informed about technical aspects of policy decisions. The Scientists' Committee does not take a stand in support of or opposition to any of the bills that are before this committee.

I shall present today some comments based on our research and experience with emphasis on points which appear to have been neglected in the current debate on national health legislation.

PLANNING

It is feasible to plan services and allocate funds to a region or a community on the basis of the frequency of various diseases in the region or community or of estimates of health care needs made at the time of periodic medical examination of an adequate sample of people in the region or community. Such an approach to allocation of funds is more direct because it is based on measurements of actual needs, as compared with one based only on past expenses for health care, population of the area, decisions of providers or mere reimbursement of providers.

QUALITY OF CARE

Our research indicates that quality of health care to a community may be broken down into five components: (a) technical quality, that is, adequate performance of health care procedures; (b) human quality, that is, the preservation of the individual's dignity and health rights and the minimizing of suffering and anxiety; (c) safety of the health care process, that is, prevention of harmful side-effects of medical or surgical procedures or treatment; (d) equitable distribution of health care resources among all persons in the community based solely upon need for health care; and (e) cost-effectiveness, that is, choice of the least costly way of accomplishing the same end-result.

The bills now before Congress tend to pay little attention to quality control or to define it in narrow terms. We believe that the success of national health legislation will depend in part upon its impact on all the components quality of care that we have just defined.

NATURE OF HEALTH CARE SYSTEM: HEALTH INSURANCE OR HEALTH SERVICE

All bills that are now before this committee are of the national health insurance type. Yet this is only one of the two major types of health care systems in the world, the other being a national health service. Some countries like England that had tried the insurance approach have abandoned it and turned to a national health service approach.

Thus, it is unfortunate that the American public has not been presented so far with the full spectrum of national health plans alternatives that are feasible, since there are at present no national health service proposal before Congress. However, I understand that Representative Dellums is working on a National Health Service bill and plans to introduce it in Congress in 1976.

PLURALISM IN DELIVERY AND ADMINISTRATION OF CARE

By pluralism we mean the coexistence of several subsystems of delivery or financing within the health care system.

While the advantages of pluralism in terms of flexibility have been well pointed out in previous hearings on national health legislation, its disadvantages in terms of inefficiency and costliness have not received as much attention. Increasing the number of plans or of administrative structures for the financing and delivery of care increases markedly the administrative cost and makes quality control more difficult to achieve. Along the same line, a multicategory system of benefits, with different benefits or administrative structures for people in different categories of income, is an obstacle to unified planning.

FINANCING OF CARE

In this instance, too, the American public has not been presented with the full spectrum of alternatives for financing health care. One missing legislative option is one in which the financing mechanism would shift a greater part of bearing the cost of the Nation's health care to higher income groups than in the bill presently before Congress.

COST-SHARING

Arguments pro and con cost-sharing (that is, coinsurance and deductibles) have been based on the premises that cost-sharing would limit utilization of services, thus preventing overutilization of unnecessary services, but also decreasing utilization of desirable services such as preventive measures. There are little hard data on how effective cost-sharing is in controlling utilization of unnecessary services. Cost-sharing might inhibit the utilization of preventive, health maintenance, rehabilitative, and even some necessary curative services, especially in low-income populations. Furthermore, there are other ways besides cost-sharing for limiting utilization of unnecessary services, such as incentives to providers for better utilization.

HEALTH RIGHTS

Most bills before Congress find that individuals have a right to health care. We believe that this statement is liable to be misinterpreted or abused, unless it is specified that individuals have a right only to the health care that is needed for maintenance or restoration of health.

Any attempt to rectify the maldistribution of resources and services has to take into account the effects of racism, sexism, and other forms of discrimination on health and health care delivery; among such effects are the far higher mortality and morbidity in low-income blacks, the neglect of health care and social rehabilitation of mentally ill and mentally retarded people, the inadequate supply of physician services in low-income areas, and the underrepresentation of blacks and of women in health professions.

ACCOUNTABILITY

Some of the health legislation of the 1960's introduced the concept of accountability of the health care delivery system to the consumers or users of the system. Because of overambitious aims and some program failures, some of the ideas on which the programs of the 1960's were based have fallen into disrepute. However, the validity of the concept of accountability to consumers has not been disproved. Therefore, it would be desirable if the subcommittee might consider, along with the patterns of accountability presented in the bills that have been introduced, alternative patterns that would give a more significant role to consumers in decisionmaking and accountability.

SPECIAL ASPECTS OF HEALTH CARE THAT ARE OMITTED OR POORLY DEVELOPED IN THE NATIONAL HEALTH INSURANCE BILLS NOW BEFORE CONGRESS

Most of the bills that are now before Congress emphasize the need for more prevention and primary care. Yet they pay little attention to certain specific measures that would contribute to these aims. For instance, occupational safety and health is an important factor in prevention, yet consideration of it as an essential element of the health care system is neglected in all the national health insurance bills before this committee.

Also rehabilitation and special health care needs of people who are mentally or physically handicapped received little attention in these bills. Notwithstanding previous legislation dealing specifically with occupational health or developmental disability, these areas of health care would tend to suffer if they are not fully integrated within the national health legislation that is to come out of this committee.

Along the same lines, if the legislation is to emphasize prevention and primary care, then provisions might be made for (a) health education of the public; (b) increased education of health care personnel about prevention and primary care; and (c) mechanisms to give responsibility for prevention and primary care to a wider range of health personnel than at present.

PUBLIC INFORMATION

Last, but not least, the question of public information about the proposals now before Congress. The Scientists' Committee has found the public to be very poorly informed about these proposals, and for that matter about most aspects of national health care. It should be an important function, not just of voluntary organizations such as the Scientists' Committee, but also of the Federal Government and of Congress to prepare informative material, in easily understood language about alternative health plans (whether introduced before Congress or not) and about the major issues and arguments related to the issues. Such public information might bring feedback from the public that would facilitate the work of this committee.

Thank you, Mr. Chairman.

Mr. Rostenkowski. Thank you, Doctor.

I want to thank you all for the expression of your very strong viewpoints. We certainly appreciate the fact that you have taken time to come here.

As well as the Chair can handle this, we look forward to you experts having an interesting exchange of ideas, making comments on each other's testimony, if you would like, with the possibility of us joining you and in your discussions.

Mr. Delaney.

Mr. Delaney. Mr. Chairman, I would simply like to comment on Mr. Rockwell's testimony. He pointed out that HEW has estimated that the cost of the Health Security Act would be in the neighborhood of $113 billion. One of the strong arguments against passage of any national health insurance bill is the cost.

What the people forget to say is that we are already spending $113 billion on health care in this country. It is not a matter of whether or not we can afford it. We are already affording it. The question is are we going to move forward with the legislation that will hold these costs down to less than $300 billion, which Mr. Rockwell predicts is going to happen if we pass comprehensive National Health Insurance?

He did forget to say, in criticizing HEW, that just prior to the enactment or prior to medicare going into effect, that the health care costs greatly went up, and doctors greatly raised their fees just piror to this bill's enactment.

One of the reasons was because they were afraid that they weren't going to get their cut of the pie when the money began to flow.

It has not been as much HEW's fault as far as inflation is concerned as it is the fact that the medicare bill did not have any cost control built into it. The reason it did not have any cost control built into it is because AMA and other health professionals lobbied against the inclusion of any cost controls in this bill.

Medicare has been a good bill for many people in our Nation. The problem with medicare is that we have let it go for 10 years without doing any major revision. If we revised that bill, we won't be in the financial crisis that we are in with health care right now.

In addition to that, Mr. Rockwell mentioned that this fallacy about the free enterprise system, health care does not operate in the area of free enterprise like a lot of other things in this country. A nursing home in Little Rock, Ark., tried to get doctors to bid on providing care for the aged in that nursing home. Doctors will not do this.

The free enterprise system allows for bids to be taken. Doctors will not bid their services in Arkansas. In addition to that, doctors will not advertise in the newspapers and get competitive with their fees.

There is nothing about free enterprise connected with the delivery of health care in our country. We, as patients, simply pay the costs, whatever they are, and we have no role in setting that cost.

Mr. Rockwell also said that if we pass comprehensive health insurance that the system will be inundated with a bunch of hypochondriacs. I suppose what he would like to do is to continue rationing health care on the basis of those who can afford it. He says that the bureaucracy, with a comprehensive health insurance, will ration health care. Health care is already rationed in this country. Millions of people go without care simply because they cannot pay the cost or cannot get to adequate access of that care.

He says that the system will be overrun because it is free. It is not free. We are paying for it and we are paying out of the nose for health care costs in this country. It is not free. Everybody pays for his health care in this country or he is treated very badly if he can't pay. He is badgered.

He also said that the Government will control the records. I wonder what he thinks happens to the insurance forms that our doctors fill out and send back to the insurance companies. These are programed by the Medical Records Bureau in Boston. Every time I go to the doctor and the doctor fills out an insurance claim on me, they keep records on my illnesses and that is for a purpose. That is to exclude me from purchase of any additional insurance in case I have suspected illnesses that might crop up.

So I would simply make these comments in reference to his testimony, Mr. Chairman.

Mr. ROSTENKOWSKI. Mr. Rockwell?

Mr. ROCKWELL. Well, Mr. Chairman, I don't know if I can remember all the points Mr. Delaney made.

I think he is quite right, that the cost probably would never get to $300 billion simply because the Government will have to clamp on the kind of controls that would cause the rationing that we see in Britain.

He also said that the patients under our present system have no role in setting the costs. I don't know how much of a role people have in setting the costs of any Government function. I mean the average person has no say over what the Post Office charges or what HEW does or what the Pentagon does or any Government operation. We do have more control when it is private.

As to medical records, I myself think that is an abuse of the way medical records are sent to that bureau which is in Greenwich, Conn., not in Boston.

I think something needs to be done and something is being done about that in a private way. The doctors have forms where no doctor should send your medical records to an insurance company without your approval. If he does, he is acting very unethically.

We have another example of what happens. By the way, I did not say medical care was free under the present system. Nothing is free. It wouldn't be free under national health insurance. It is not free now. But under the systems of health maintenance organizations we have a setup where people pay a set cost and then can use it as much as they want.

I know that the doctor who founded the Kaiser Permanente HMO in California, which is probably the most successful one there is, said he had originally seen the price the patient pays to get medical care as being a barrier to getting care. But he found that, after removing the price, actually the removal of the price was even more of a barrier to medical care simply because the system was flooded and he had to design ways—which he did do—of cutting down demand in other ways, that when the price was removed and it became "free," the system was flooded.

It is too bad that is the way things are. We all wish that the Government could provide us with everything and we would all be happy. But things don't work like that in the real world.

Mr. Rostenkowski. Dr. Dorrity?

Dr. Dorrity. Yes, sir. I have a lot of things to say about this. I feel like a chicken in the fox house. But even though I am outnumbered, I don't think you determine right and wrong by a majority vote.

I would like to set the record straight on several things. When it was stated that American medicine is getting worse all the time, that is certainly contrary to the facts. If it were better in any other country, where do you think Anthony Eden would have gone for surgery on his common duct? Where would the Duke of Windsor go for his aortic graft? Where did King Faisal take his family?

They came to the United States. If it had been cheaper on the Moon, or, they could have obtained better care on the Moon, they would have gone there. Money was no object. They could have gone anywhere else very easily, if they had thought they could have received better care.

When anyone says that the free enterprise system is a failure, he hasn't done his homework. There is really no new thing under the Sun except that part of history we don't remember.

Is there any country in the world which has done better, earlier, at a faster rate than the United States when we were on the free enterprise system, which has rapidly been destroyed? There is nothing in the world that will increase the quality, and lower the cost more than free competition in the marketplace, with free and willing exchange between those who have services and/or goods to sell. It could not be surpassed anywhere.

When it is stated that there are patients in the millions without medical care, this is contrary to the fact. For the last 5 years I have been chief of surgery at the Methodist Hospital in Memphis. This is an elective office, it is not an appointive one. We have over 1,000 beds. We have always taken care of the poor and indigent.

Nobody ever mentions money before treating emergencies. This is right across the Mississippi River from West Memphis, Ark. Our batting average is excellent as far as admissions and treatment. I have taught preoperative stop care, along with surgical technique, and I know the type medicine and surgery that our people do. It is the best in the world.

There is no question about it.

Our patients are not badgered. I don't know what happens in other places. I imagine, perhaps, an occasional one that is being referred to, is the one that makes the headlines. It is not the millions and millions who are taken care of properly.

Insurance forms, as far as our area is concerned, have always been a thorn in our side. Frankly they get no information on any of my patients except that pertaining directly to the present illness, that is, pain in the belly and the diagnosis and what was done. If they write for additional information and do not include a self-addressed stamped envelop, they get no reply. If they do, I tell them to see the previous letter.

What grandma and grandpa had is not their business and I don't tell them.

I could go on.

Mr. Rostenkowski. Sister Foppe?

Sister Foppe. I would like to agree with the comments of Mr. Delaney 100 percent.

I would like to add to those that I agree with Mr. Rockwell that we have the best scientific medical care in our country. But the problem is 16 percent or more of the American people cannot touch it. That is a problem that I see. I am not in disagreement that we are limited. We have the best. But why must the working poor, the low-income people, be denied any medical care?

In my particular office that I work from, I see these people who are denied. There is no way that you can get help for them from medicaid unless they fit in the right income bracket. There is no help for medicare. There is no help even from our Texas Technical Medical School.

If you are in the wrong bracket of income and you have $5 or $10 too much, you are out and you pay the price of the wealthy person.

This is my concern. What is happening to these people? They go 5, 10, 15 years without going to a doctor. They are feeling badly and you say, "Why don't you go?" I can't afford it. I will have to wait."

And the wait until finally it is too late. When they go, you hospitalize them and then you carry them from the hospital dead. This is what I am concerned about.

I think, with all the know-how we have in our country, if we have got the motivation, we can find a way to correct this problem.

Mr. Rostenkowski. Sister, one comment before we go to Dr. Jahiel. In all the polls that have recently been taken, national health insurance has not even hit the scale as a national priority. In the most recent poll conducted by CBS just the night before last national health insurance did not even appear on the list of priorities. Do you have any idea as to why this should happen?

Sister FOPPE. This is an educated guess. The people who need this the most are not the ones being touched in the polls. I think you are getting a copy of my tabulation.

Mr. ROSTENKOWSKI. Yes, and we are going to have those in the material for the committee to look at, Sister.

Sister FOPPE. You will note that these people have no input. First of all, their education is very limited. The group that I worked with on the whole have an education from zero through grade 8. They are so busy struggling, trying to make a living and to live conscientiously within the law, they have no time for these things because they are simply trying to hold a daytime job and a moonlighting job.

When things get too bad and they break down, then we have got them in the hospital for a long time. Like I mentioned, there is no way that these bills can be met. I think it is ignorance on the part of a great part of the American people, and it is indifference on another great portion of the American people. They are saying to themselves, "Well, I am making it. Why should I bother about the other fellow? I am pulling myself up."

I am not sure he is. Somebody else has been pulling him up through the other programs. So he didn't really care about his neighbor.

Mr. ROSTENKOWSKI. Dr. Jahiel?

Dr. JAHIEL. One thing is for people to be concerned about their health and field of sickness and the other one is to be able to connect this with national legislation.

It seems from my talk with various community groups and various people that there is a great deal of interest in one's health and a great deal of fear of what will happen if one is sick.

But there is a little understanding of how this could be affected by reorganizing priorities in the health care system, and little understanding of what could be done with more prevention, with more primary care, with attempts to distribute health care more evenly.

I think this is where there is need for more public education, to inform the public of not just what are the problems of sickness, but what can be done about it. If the public finds that something can be done about it for improvement, then it is possible that the interest would rise considerably.

With respect to Dr. Dorrity's comment, I would again say that it is important to keep the same excellent level of specialized service which exists in American medicine, but attempt to improve the primary care, the prevention and the accessibility of various groups of people to all those services.

Also, another area that needs considerable improvement is rehabilitation.

Mr. ROSTENKOWSKI. Thank you, Doctor, I will now ask the members of the committee to join in the discussion.

Mr. Duncan?

Mr. DUNCAN. Thank you, Mr. Chairman.

I would like to ask the Sister, what is the Texas Committee for National Health Insurance?

Sister FOPPE. The Texas committee is affiliated with the Heal Security Act, which was established here in Washington.

Mr. DUNCAN. With the heal what?

Sister Foppe. The Health Security Act program. They are here on 15th Street NW., I believe. I have been working as an individual person in west Texas.

Mr. Duncan. How many members do you have?

Sister Foppe. I couldn't answer that because I have just been working as an individual in west Texas.

Mr. Duncan. Do you have hundreds in Texas?

Sister Foppe. I couldn't answer that.

Mr. Duncan. I am interested in what the group is.

Sister Foppe. I was called and asked if I would represent the people of Texas. I have been working with them for the last 3 years, but I have not been able to attend meetings and things of this nature. I have been working primarily among the poor in west Texas. I do not have any committee funds nor any time to be traveling around the country.

Mr. Duncan. Any member of the panel might answer this question. What do you believe would be the best way to encourage and utilize physician extenders under our present system?

Dr. Dorrity?

Dr. Dorrity. I didn't understand the question, Mr. Duncan.

Mr. Duncan. What do you believe would be the best way to encourage and utilize physician extenders under our present system?

Dr. Dorrity. Physician extenders, are you talking about——

Mr. Duncan. I am talking about the nurse practitioners in the rural areas. We have some in our State of Tennessee

Dr. Dorrity. I don't think there is any place for it. I wouldn't use any under any circumstances unless they were working directly under me. Some like them, but I would not trust them, with a little bit of knowledge, taking care of any of my patients unless they were directly under my supervision.

I think it is dangerous.

Mr. Duncan. I have visited some of the clinics that are being operated by nurses at this time. Their work is reviewed, I think, once a week by a physician. They are doing great work in some of our rural remote areas of eastern Tennessee. You probably don't——

Dr. Dorrity. Thirty-five or forty years ago the nurses would make rounds, but what would happen between visits, when the doctor was checking on it, you could get into an awful lot of trouble in the interim if they did not realize their capabilities. Some of them do. But blanketly they don't.

Some of them would not ask for help because they were determined to follow through on their own. I think this is dangerous.

Mr. Duncan. I visited some of these clinics and I must say that I was impressed with what I observed.

I want to get back to Sister Foppe. If the Government takes over all of these programs, then what happens to the Good Samaritan ship that you and I were talking about a long, long time ago and the charities and the hospitals that operate under charitable giving, what happens to all those? Are you going to let the Government take over all that?

Sister Foppe. If they spent their time doing their job well, I think in that very way they would be promoting what they should be promoting as Christians.

I cannot see that we should, because a hospital or the Sisters, whoever you are referring to, would be doing this Good Samaritan work and 5 percent are taken care of and 95 percent are not going to be taken care of because there are not enough Good Samaritans around. We have to then shift priorities and find a way, and there will probably be some Good Samaritan work.

Maybe it will hit the headlines and maybe it won't.

Mr. DUNCAN. Would anyone else like to respond?

Dr. DORRITY. Yes; I would, especially when they touched on the Christian attitude. It is one thing to show charity, voluntarily, out of the goodness of your heart, and quite another, the big brother attitude, when you are told to give. Do you have to be told what you want? Most people in our area usually find a way to get the things they need and want. We don't have this problem that the poverty-stricken are not taken care of, because you arbitrarily pick a certain income level below which is considered poverty.

In 1929 the $150-a-year income was a lot of money for some. But the dollar was worth a dollar at that time. Now, with the decreased buying power of the dollar, 75 percent lost since 1960. Compare that with the dollar in 1900, it is worth about 10 cents.

So the increase in cost is not reflecting the true happening here in America. It just takes more of the worthless dollars to buy everything. Every time you increase a handout, without a willing exchange or without something in return in goods and/or services, you decrease the buying power of the dollar in your pocket still further.

With this present trend, if you will remember it took a bushel basket of marks to buy a loaf of bread in Germany. It will take more than that right here unless we get back to sound money and individual responsibility. This is where the guts of the whole matter is. It is the individual's responsibility, No. 1, to take care of his own needs and wants, and his relatives, the church next, the local community next, and then the State level.

I don't think the Federal Government needs to get into this. In fact, I think it is unconstitutional.

Mr. DUNCAN. My time is up. I would like to talk further with you. Thank you, Dr. Dorrity.

Mr. ROSTENKOWSKI. Mr. Corman will inquire.

Mr. CORMAN. Thank you, Mr. Chairman.

I would like to say, particularly to Mr. Delaney and Sister Foppe, that I very much appreciate the fact that you are out there working for the health security program. You are so articulate and so knowledgeable about its provisions and can answer the charges that are leveled against it.

I think we will have that program within the next 3 or 4 years. that is, we will take the first step toward it, which will be enacting legislation. When we do, it will be only because of people like yourselves who are helping us explain it to the American people.

Looking at what there is in the way of free enterprise or competition in the medical field, the fact of the matter is that we prohibit, through exercise of the police power, 99 percent of the American people from entering into the field. I wonder how those who advocate unrestrained free enterprise feel about all that. Ought we to say to more than 99 percent of the American people, "You may not deliver health care. We will put you in jail if you try." What does that do to the free enterprise system, Dr. Dorrity?

Dr. DORRITY. Are you referring to the fact that it is hard to get in medical schools?

Mr. CORMAN. No, hir. I am referring to the fact that under the law I have to be in a very select group of people to be able to practice health care. In other words, under the free enterprise system, as you build a better mousetrap people will buy your product. But we say to over 99 percent of the people we do not allow you to build a mousetrap.

If we really want free enterprise, why do we not just let anybody practice medicine who decides he wants to and let the consumer pick and choose?

Dr. DORRITY. Mr. Corman, they had some diploma mills for some time and they have been prosecuted for this. When you talk about medical care and health care, you must not confuse the World Health Organization's definition of health care, which includes food, clothing, lodging, money in the pocket, sewage and garbage disposal. Doctors can deliver medical care only. If the people are qualified, they can go into any of these areas they want, but the policy is here.

The trap is, when they make an application for medical school and take the preentrance examinations, for the last 10 years at least, the grade points have progressively gone downhill. This is a fault of the public school system and intervention by the Federal Government.

Mr. CORMAN. But I still have not had a response to my question. I am a consumer; why should the Government tell me that I cannot select anybody I want to take my appendix out? You do not let me do that. The law does not let me do that.

Dr. DORRITY. And you couldn't do it at the Methodist Hospital in Memphis so long as I am chief of surgery unless the man you select is qualified to do surgery.

Mr. CORMAN. But why should you make that decision? I am the consumer. I ought to have a chance to go out and spend my money the way I want to.

Dr. DORRITY. We have some people who are knowledgeable in certain areas and some people who think they are. But this is not a parallel. It is a matter as to who is judge. We have an excellent hospital and our batting average is good.

Mr. CORMAN. Yes, sir. But if we are going to leave it to the consumer to make the decision, that is the free enterprise system. You substantially cut back on my opportunities for that decision.

Dr. DORRITY. That happens in some areas, but it doesn't happen in our hospital.

Mr. CORMAN. It happens in our country, Dr. Dorrity. If I lived in your city, I would not be able to go out and pick and choose anybody I want to cut off my toe. I would have to go to somebody the State says I have to go to. That is not free enterprise.

Dr. DORRITY. No. You could go to a podiatrist and he would be happy to take it off. In fact, I don't think the indications would be as properly evaluated as if you would consult an orthopedist. You can inquire around from any of the medical societies as to those who are competent in that area and this is to help you, not to hinder you.

Mr. CORMAN. Yes, sir. That is what national health insurance is for, to help you, not to hurt you.

Dr. DORRITY. For example, who in Washington could tell me better how to take care of a patient down in Memphis than I could when I am sitting there with my hand on his abdomen and listening to him while completely examining him?

Mr. DELANEY. I could help.

Dr. DORRITY. I don't want that kind of help. With friends like that I don't need any enemies.

Mr. ROCKWELL. Mr. Corman, I agree with you. I want to make clear I am speaking only for myself and not for the Congress of County Medical Societies or Private Practice. I am sure you are familiar with Dr. Milton Friedman's article on the whole question of medical licensing He demonstrates that it is wrong for government to license doctors.

I think it is wrong for the State to tell me that I can't do plumbing work in my house if I am not a licensed plumber; that I can't do my own electrical work; that I have to be a licensed electrician.

You have to have a license to be a barber and to enter many other professions. I agree that the State should not be licensing any profession.

Mr. CORMAN. I do not share that view.

Mr. ROCKWELL. I know you don't.

Mr. CORMAN. It is interesting to fix the parameters of where we are on free enterprise. I must say you are a purist. I am glad if anybody is ever going to whack off my brain, someone is going to license him.

Mr. DELANEY. Mr. Corman, you touched on a point that is really very close to the consumer's heart. That is, that he has such a small voice in the whole matter of delivery of health care, when he is very qualified to do it. I know how to put a bandaid on my finger and I know how to do a lot of things. We have heard from a professional tell us that nurses are incompetent to do anything other than the kind of work they are doing now.

The only people who are really competent to deliver health care in this country are doctors. You have got to keep that union very tight. You have got to keep it, otherwise you get too many people making decisions and doctors lose control of the way medicine is delivered in this Nation.

I think the consumer would be all for physician extenders, whatever you want to call these people, who can help get care to people who need it. And there are many, many nurses who can deliver health care just as well or better than many doctors.

Dr. DORRITY. I didn't say that the nurses were incompetent. I said some of them don't know their limitations and this doesn't apply just to nurses. This applies to doctors and people in whatever endeavor you are in. But the thing about it is to remember what your limitations are.

In my training I cracked skulls. I pinned hips, that type of thing. But I specialize in general surgery and let the orthopedists, who do nothing but this and do a better job, I send them to them.

The neurosurgeons I know do a better job on the trephine. This is how you get better care to the people.

Mr. ROSTENKOWSKI. Mr. Burleson will inquire.

Mr. BURLESON. I will pass, Mr. Chairman.

Mr. ROSTENKOWSKI. Mr. Crane will inquire.

Mr. CRANE. Thank you, Mr. Chairman.

I would like to respond to my good friend from California on a couple of points he raised here.

One, I don't think anybody would deny you the opportunity to apply leeches to yourself. I suspect you can find somebody in the free market who will sell them to you.

Second, I think Mr. Delaney is essentially refuting the position you are trying to take by suggesting you go to a nurse and get treated instead of exercising the good judgment and wisdom I know you have to find a good, competent professional. I don't think that you would simply go out to a local barbershop to have him perform surgery on you today. You would be more discriminating then.

Mr. CORMAN. Remember he would not do it anyway, because they would pack him off to jail.

My point is there is not anything in the free enterprise system that applies to the medical sector.

Dr. DORRITY. If you come to Memphis, I will see that you get the best, Mr. Corman.

Mr. CORMAN. I want to see your license first.

Mr. CRANE. I would like to ask you, Mr. Delaney, a question that Mr. Duncan raised with Sister Foppe. That is, what is the Arkansas Committee for National Health Insurance?

Mr. DELANEY. The Arkansas Committee for National Health Insurance is a consumer organization that has a membership in the neighborhood of 2,000 people in Arkansas. Its purpose is to help people become aware that they do have a voice in the way decisions are to be made and that we would very much like to help be their spokesman if they have grievances.

We also lobby for passage of better health care legislation in the State of Arkansas and at the national level.

Mr. CRANE. Do you have a national affiliation that Sister Foppe's group has?

Mr. DELANEY. I work closely with the Health Security Action Council here in Washington, D.C.

Mr. CRANE. In other words, both Sister Foppe's organization and yours are simply affiliates of a national organization based here in Washington?

Mr. DELANEY. We are a State organization, yes, independent. We are not linked with them financially. We are only linked with them philosophically.

Mr. CRANE. You have no ties with the Health Security Act group that Sister Foppe referred to then?

Mr. DELANEY. Well, we have certain ties, philosophical ties. We work for the passage of the same legislation.

Mr. CRANE. By philosophical ties what do you mean? I am a Republican and I have philosophical ties with the Republican Party nationally. Do you have any direct link? That is the thing I am curious about.

Sister Foppe, you indicated there is a direct link between your Texas committee and this organization here in Washington.

Sister FOPPE. I would say on the same basis as his. If I need help and information, I call in to know where we are standing because we are out there in Texas.

Mr. CRANE. But you are in no way related to this organization here in Washington?

Sister FOPPE. No, not as an individual.

Mr. CRANE. I mean your organization, the Texas Committee, has no connection whatsoever with the Washington-based group.

Sister FOPPE. I am sure they are affiliated philosophically, yes. That is, as far as I have been working with them, because I am way out there in West Texas by myself.

Mr. CRANE. Mr. Delaney, about the organization here in Washington, what is the full title of that organization?

Mr. DELANEY. The Health Security Action Council, I guess, is the group that lobbies here in Washington. They are part of the Committee of One Hundred for National Health Insurance, which is a national group. I am affiliated with that group. I am a member of the Committee of One Hundred for National Health Insurance. But as chairman of the Arkansas committee I am not part of their organization in that I receive any funds for operation of our Arkansas committee.

Mr. CRANE. You raise all of your Arkansas funds within the State, you mean?

Mr. DELANEY. Yes.

Mr. CRANE. Is that through voluntary subscription?

Mr. DELANEY. Yes, it is through fundraising, organization, people who share our philosophy of national legislation.

Mr. CRANE. Sister Foppe, I overheard you refer to the fact that 16 percent of the American population cannot get medical care. I am wondering where you came up with that figure, because that doesn't reconcile itself with earlier testimony we have had before this committee about the number of Americans who are either insured through private companies or the Blues and people who are covered through medicare and medicaid.

Where did you get that percentage?

Sister FOPPE. I got it mostly through reading newspapers. It balances out very well with the needs of the State of Texas. So I feel that that figure is pretty close.

Mr. CRANE. In other words, you feel that 16 percent of Texans aren't covered?

Sister FOPPE. There are more than 16 percent of the Texans that are not covered.

Mr. CRANE. What percentage of the people of Texas are not covered?

Sister FOPPE. Again I will base it on the west Texas people, which is very close to 47 to 50 percent that are not covered whatsoever.

Mr. CRANE. You think 47 to 50 percent of Texans aren't covered at the present time?

Sister FOPPE. In my section of the country that is valid because it has come through the computer.

Mr. MARTIN. If I could explore that just a moment, your 47 percent is based on the sample that you took in the group of churches that you have been working with?

Sister FOPPE. Right.

Mr. MARTIN. This is a representative sample of the State of Texas?

Sister FOPPE. Of west Texas.

Mr. MARTIN. This is a representative sample of the State of Texas that would lead you to extrapolate that 47 percent to include the State.

Sister FOPPE. I would be willing to include that because the southern part of the State of Texas, round the Rio Grande Valley, is in the same position as west Texas. Though it may be higher in other sections of the State, better coverage, the coverage in the Rio Grande Valley is going to be lower.

Mr. MARTIN. I was a little curious about the sample you gave, because you mentioned there were 918 individuals who were within the poverty level and yet only 59 were eligible for medicare and medicaid.

I didn't know whether there was any significance to the point that you made that about 99 percent of these people in all but one of the churches were Spanish-surnamed. I don't know whether there was some significance to that.

Sister FOPPE. All of these churches, with the exception of St. Elizabeth's, that gave a very poor return, were almost 100 percent Spanish-surnamed in the parish.

Mr. MARTIN. That is representative of the State of Texas?

Sister FOPPE. That represents west Texas. There is a very large Spanish-surnamed population in there. And they are pretty much in the same situation because I took one parish in the city which I considered low-middle income, which was Our Lady of Grace. I took two rural parishes, Lorenzo and Ralls, which come out of Crosbyton, which is a very good picture of Spanish-surnamed in agriculture in west Texas. In fact, they are probably a little bit better off than some sections of west Texas.

The Spanish-surnamed people have the worst health coverage in the State of Texas and they represent approximately 18 to 20 percent of the population of Texas.

Mr. ROSTENKOWSKI. Thank you.

Mr. Cotter.

Mr. COTTER. Thank you, Mr. Chairman.

Sister Foppe, we have figures which have been submitted by the Department of Health, Education, and Welfare, which indicate that nationwide—and I think you are on target—22 percent of the population doesn't have even the basic hospital care. I am inclined to think your figures are about right.

What concerns me, Dr. Dorrity, is how would you handle this 16 percent or 22 percent of the population who doesn't have health coverage? What would you propose? How do we attack it?

Dr. DORRITY. When you say "health coverage," do you mean private insurance and whether or not they qualify under one of the Government programs?

Mr. COTTER. This is 22 percent of the population under age 65 only doesn't have any coverage whatsoever and 78 percent of the population has basic hospital coverage. How would we take care of these 22 percent of the population?

Dr. DORRITY. We would take care of them like we have always done. We have the charity clinics in every hospital in town and Memphis is a great medical center. We have certain days for the surgery, the GYN and the medicine, on a routine basis. Those who have an emergency would be seen anytime. In fact, since medicare and medicaid, the charity service at the John Gaston Hospital has fallen off so drastically that they are having trouble now with material to teach the students and have asked on many occasions to use the private patients to help teach the medical students.

There is no problem obtaining beds in the John Gaston Hospital, which is entirely charitable. We have wards that are vacant, no beds occupied at all. This is not a problem, certainly not in our area.

Mr. Cotter. Let me tell you that the hospital in my area, through their hospital associations, have come to me and want median pay for their bad debts. Believe me, in my hometown, which is a sophisticated area, they can cart someone in off the street into the hospital and unless there is someone there to sign for him and take responsibility for his debts, that person is in serious trouble. So I don't think that the charity end of it is going to take care of most poor people.

Dr. Dorrity. In our area that is not a problem. They are not asked about money or who is going to be responsible when they come in as an emergency. They are taken care of, period.

If, afterward, there is somebody who can help with the financial situation, they welcome it because there is a lot of expense to this. But it is not the No. 1 question that is asked.

Mr. Cotter. Then in your area, anyone who is in need, who can't pay, can go into the hospital and have care free. Is this what you are telling me?

Dr. Dorrity. Certainly it is not free. Somebody has got to pay for it. But, if a patient is brought into the Methodist Hospital, the Baptist, the St. Joseph, or the Charity Hospital, the John Gaston at the university, he is treated in the emergency room, period.

Mr. Cotter. And not charged for it if they can't pay? Is this what you are trying to tell me?

Dr. Dorrity. That is correct.

Mr. Cotter. This is very refreshing to hear. I wish it were common in every city and every town in the country. But my experience shows it isn't. This would solve all of our problems, but I just don't think it is realistic.

Dr. Dorrity. I think some of the problems we have now are created because there are so many people and hospital associations who feel like that. They spoil it by coming up and asking for money for the bad debts. The easiest course for them to take is to run to Washington with hat in hand, asking for a handout. They have been like Pavlov's dog, conditioned to run up to "big brother." This, I think, is a horrible mistake. I wish it had never happened.

Mr. Cotter. What do you do about your bad debts in your hospital down there?

Dr. Dorrity. In our hospital?

Mr. Cotter. Yes.

Dr. Dorrity. We have a collecting agency like anybody else because we have a certain amount of overhead to take care of. When we were forced under the minimum wage, even the people who clean up the rooms—and this was of your doing—we had to have people around the clock, 8-hour shifts for 24 hours a day. This immediately increased the cost of operating the hospital.

We have to pay these people the so-called minimum wage, whether they earn it or not. And so many of them loaf because they know they are going to be paid whether they work or not.

Where it requires, let's say, a hotel, for example, 6 employees can take care of 15 or 20 people, but it takes about that many employees to take care of 6 patients in the hospital. Our increased cost of operation continues to go up commensurate with the decreased buying power of the dollar, plus being forced under the minimum wage.

Mr. COTTER. This is fine, but we still haven't solved the problem of what to do with this percentage of population who have any money. They may have a job at $5,000 or $6,000 or $7,000 a year. They don't qualify for medicaid. What do they do?

You say the hospitals take care of them free. I don't find this to be true in most parts of our country.

Dr. DORRITY. When they take care of them, it is not free.

Mr. COTTER. Let's get back to the point of the guy who has no resources, a modest income. He doesn't qualify for medicare. He is taking in $5,000 a year. Let's assume he is above the poverty level. What does he do? He can't afford $100 a day.

Dr. DORRITY. Certainly not. That is why we have the charity services, and they don't pay $100 a day. That $100 a day——

Mr. COTTER. Does he have inferior care?

Dr. DORRITY. Absolutely not. We don't have that type care in our area. In fact, the charity patients get better care than anybody else because they automatically have the specialists to see them for whatever particular system, and every paying patient does not, unless his particular physician calls in consultation. He gets excellent care.

I have heard that many times and it kind of rubs me the wrong way.

Mr. COTTER. Thank you, Doctor. My time has expired.

Mr. ROSTENKOWSKI. Mrs. Keys will inquire.

Mrs. KEYS. Thank you, Mr. Chairman.

Our time is vanishing. I would like to make two remarks. I would like to thank Dr. Dorrity for recognizing his own limitations in reference to the statement of policy of the World Health Organization. I think it is a very fine statement and, quite wisely, you said that was something you couldn't deliver. I think many of us here feel the awesome responsibility of the necessity of our insuring that our citizens have access to those very basic rights.

I think that is why we are sitting here listening to all of you this morning and trying to do something about health care in this country.

The other observation I would like to make is to underscore and congratulate Dr. Jahiel for bringing to our attention three things that I think are most important as we move, that we do have provisions for health education for the public—I really haven't heard that stressed enough by witnesses before us—and also mechanisms to move the delivery of health care out into a much broader scope of personnel.

I think if we are ever going to do the job of prevention care and really providing for the health of Americans, we are certainly going to have to do that. I appreciate so much your emphasizing those things.

Thank you very much.

Mr. ROSTENKOWSKI. Mr. Martin will inquire.

Mr. MARTIN. Thank you, Mr. Chairman.

I would like to explore a little further the point that was being made by the gentleman, Mr. Cotter, regarding the 22 percent of people who were not covered by private insurance. There are a couple observations I think need to be made about this.

This is based on the document "National Health Insurance Resource Book." A table on page 75 and explanation of that on page 74 indicates that about 22 percent of the population under age 65 was not covered by private insurance. But you would also have to take into account, first, that medicaid covered about half of these, which means that for the year for which these statistics are applying, that at that time only 10 or 11 percent were not covered by either medicare or private insurance.

The second thing you have to take into account is the testimony that was recently presented to us, I believe, by the representative of Blue Cross-Blue Shield, that indicated that as of today the percentage of people who are covered by private insurance has grown from that 78 percent of 1972 to a level of about 87 percent now.

Mrs. KEYS. Would the gentleman yield?

Mr. MARTIN. Yes.

Mrs. KEYS. Thank you. I wanted to refer to, since Mr. Cotter had left and I know he would have liked to have pointed this out to you, the fact that these statistics still only reflect those who have coverage for hospitalized care. It doesn't really reflect any other kind of coverage. In fact, the percentage is much different when you talk about doctors' visits, et cetera. It is very, very low.

Mr. MARTIN. I was going to get to that in just a moment. But since you have called my attention to that, what this chart indicates is that the 22 percent who are not covered by private insurance refers to people who don't have hospital care and surgical services care. That is, at that time in 1972 this is an average of the two columns, 78 percent had hospital care and surgical services care. The kind of things they didn't have, almost the same percentages, roughly 76 percent, had in-hospital visits, had coverage for X-ray and laboratory examinations. The things they didn't have were insurance to pay for their office visits, for dental care, for prescribed drugs.

Only about half of them insured themselves for that, but for hospital care, X-rays, and the other—76, 77 and 78 percent of the people—were covered in 1972 for those purposes and that coverage has increased to date in all of these categories, according to the testimony that we had from Blue Cross and Blue Shield.

In addition to that, in addition to the roughly 85 to 87 percent of the people who are covered by insurance, half of the remainder are covered by medicaid. So this very markedly reduces the figure that you are using to talk about the number of people who are not now covered. That is still a group that has to be dealt with. It includes people who are perhaps technically uninsurable because of some existing heart condition or medical condition. It includes people who are retired at age 62, but are not yet eligible for medicare that comes on at age 65.

I think there does need to be some attention to that. But that by itself, that small percentage of people, doesn't justify revamping the entire system of medical care for the 94 percent or so of the people who are adequately taken care of.

Mrs. KEYS. Would the gentleman yield?

Mr. MARTIN. I would be delighted to.

Mrs. KEYS. I personally have four children, two sons and two daughters, who are nearly grown now. During the time of their growing-up years, very little of their health care took place in a hospital. I think that is the problem.

Mr. MARTIN. I don't know that that is a problem.

Mrs. KEYS. The coverage we are talking about is really coverage that has to do with people in hospitals. We need to do something about changing health care availability for people at times when not hospitalized. It seems to me we need to do a great deal to influence and to change that.

Mr. MARTIN. Let me make one further observation and the members of the panel may comment on this or not, as they please. It seems to me that we are talking about three basic concepts that have to do with medical care in this country. There is the concept of quality of that medical care.

We can debate whether the quality is adequate or inadequate. There is a question of access. I think most of the argument in favor of doing something legislatively has dealt with the case that many people are limited in their access, either geographically because there are no doctors nearby or because of financial reasons.

The third, of course, is cost. Some of the panel who are arguing for the national health care system, I think particularly Dr. Jahiel, who argued for a National Health Service, also make the point it is necessary to limit the cost, to hold down the cost.

I think you have those three basic interrelated factors. I think they wouldn't relate this way. Generally the product of multiplying quality times access is going to yield the cost. Quality times access is proportional to the cost of medical care. That means if you increase either quality or access and/or excess, the cost will have to rise. If you increase the access, but limit the cost, then the quality must decline if that relationship is true.

Or if you maintain the quality, but limit the cost, then your access has to be rationed.

I think that relationship generally flows from just about all the testimony we have had, including testimony from this panel from all of the folks who have appeared before us. You have got to balance those three factors.

If you merely aim at one of them, you are going to sacrifice on one or both of the others.

Dr. JAHIEL. I want to make a correction. I was not advocating a National Health Service. I was just mentioning this as one major alternative. It has not been discussed.

Second, the question of the relationship between cost, quality, and access may not include all the variables.

There is also the question of structuring that has to go into it, structuring of the services and also the question of unnecessary services.

So that I think one can still do a great deal about insuring quality and insuring better quality and better access without increasing materially the cost by working on the manner in which the services are delivered from the viewpoint of efficiency and also by seeing if it is possible to decrease the occurrence of some unnecessary health services.

Mr. MARTIN. I might suggest that both the question of structuring the delivery and the question of unnecessary services come within the framework of access. If someone other than the doctor is going to determine—let's say, a clerk at one of our administering agencies is going to determine that a certain patient is not going to be treated for certain surgery, then that is a determination of access of that persons to surgery the doctor and the patient may feel the patient needs.

Mr. ROCKWELL. On the whole question of determining what is a necessary health service, the British Government has made the determination for cost reasons that women only need a pap test every 5 years. I know my wife doesn't agree with that and I don't think any American woman would.

The whole idea, as Congressman Martin says, of some clerk in the HEW bureaucracy deciding these things for individuals is, I think, repugnant.

Mr. ROSTENKOWSKI. Mr. Corman?

Mr. CORMAN. On that last issue, as far as HEW is concerned, they never make a decision as to what a doctor can do for a patient. They only make a decision as to what the Government will pay for. The doctor can see a patient every day for whatever. They only say they will pay for a portion of it.

But we do not intrude on the doctor's conscience.

I want to ask Dr. Dorrity if he might submit for the record the bad debts that were referred to the collection department. I think this might give us some clues as to what kinds of people are paying their bills and what is being done about it. If you might for a 1-year period tell us what cases were referred to your collection agency to be collected, the amount of the bills, the days of stay in the hospital, if the information is available whether or not those people have private insurance, and if the information is available what their annual income is.

I think we may be focusing in on whether there is a problem and what kinds of people have it if there is. Would you be willing to submit that to us for the record, Doctor?

Dr. DORRITY. What was your first part of the question?

Mr. CORMAN. The first one is give us a list of the bad debts that have been referred to your collection agency, the amount of each bill, the number of days that individual was in the hospital, if you know it, whether that patient had any insurance, and if you know it what their annual income was.

Dr. DORRITY. I am not sure that I can get their annual income.

Mr. CORMAN. I thought it might not be possible.

Dr. DORRITY. I can get you certainly from the Methodist Hospital in Memphis the bad debts, the amounts, the numbers of days and those who have insurance and the type, if you would like. I could even get you the length of stays per patient, because that would not be hard to find.

But annual incomes, I would have no way of knowing that. I don't think anybody in my department had better ask a patient his annual income. I don't think it is any of their business.

Mr. CORMAN. Would I be safe to say if they are eligible for medicaid, they would not get referred to the collection agency? In other words, we could skim out the very poor because if they are medically eligible, they are on medicaid?

Dr. Dorrity. Medicaid would not, but I am sure this would not apply for medicare because of the obvious ramifications.

Mr. Corman. You mean there might be some medicare patients who are referred to the collection agency or there would not be?

Dr. Dorrity. There may be. I am not sure. I will have to look into this, but there is no reason why it should not. We have a lot of people who took advantage of these goodies simply because they became 65 years of age and a lot of them are independently wealthy. They didn't even have insurance when they had no medicare or medicaid.

I know several who said they would rather bear their own losses than pay the premiums. I think that is wise, too. I like that individual responsibility.

Mr. Corman. Their hospital costs are covered if they are under medicare and they do not pay premiums for that. But it would be interesting if you have medicare patients that you surcharge them to the point you have to refer them to a collection agency.

Dr. Dorrity. Many patients have insurance in addition to medicare and for many reasons. I will try to get that information.

[The information follows:]

Memphis, Tenn., *November 25, 1975.*

Committee on Ways and Means,
U.S. House of Representatives,
Washington, D.C.

Gentlemen: In answer to Mr. Corman's request for additional information I submit the following:

Methodist Hospital records of the past year, representing 370,000 patient days, reveal 13–15 percent bad debts with 3–5 percent of these considered entirely uncollectible.

Medicare and medicaid amount to 33–36 percent of our total. Of course medicaid patients are not billed; and medicare patients are billed only or those items not covered, i.e. cots in rooms, difference between double rooms, and private when requested.

Even at this, it's a losing proposition imposed by law.

Charity is 5.3 percent of the total, which runs in excess of $2 million per year. No charge is made for professional services which are donated by the excellent physicians and surgeons on our staff. This is true charity, from the goodness of their hearts, not required or enforced by the police power of tyranical federal government.

Of those patients under medicare, 85 percent have co-insurance. 92 percent of aid patients are not billed; and medicare patients are billed only for those items

Within the 8 percent with no insurance, is included the independently wealthy, who elect not to buy insurance, but to pay their own way.

The remaining small percentage receive excellent medical care, and, always will.

If you will remember your oath of office, "To protect the Constitution of the United States of America and defend it against all enemies, both foreign and domestic"; pledge Allegiance to God, America, and individual responsibility; and, in that order; and, return to sound money, with fiscal sanity, we can ride out any storm. If you do not, you will destroy the greatest country of all time.

You have the power. I pray you be granted the wisdom to make the right decision.

Sincerely,

Thomas G. Dorrity, M.D.

Mr. Corman. Thank you very much.

Mr. Burleson. Will the gentleman yield?

Mr. Corman. Yes.

Mr. **Burleson**. Will you promise me when you get this information you will read every word of it, every figure of it, and study it?

Mr. **Corman**. If it is useful I may even make a speech on it on the floor.

Mr. **Burleson**. Dr. Dorrity says it wouldn't be too difficult to compile this information, but it sounds like a bureaucratic type of request. If you would have to hire a couple of people to get this information, then if you can charge it to the patients who are able to pay.

Dr. **Dorrity**. Mr. Burleson, there are a whole lot of things I would rather do than that. There are a whole lot of things I would rather do than come up here today and tomorrow at my own expense. But if it will help to preserve the free enterprise system, I will do it and I will pay for it. But I would like to know that you would read it and give me a feedback on your breakdown of what I send you.

Mr. **Burleson**. I suggest Mr. Corman make a 30-page report back to you in response.

Dr. **Dorrity**. And I will read every word of it, if you see that he gets it to me.

Mr. **Burleson**. I am needling my good friend from California.

Mr. **Corman**. If there are 30 pages of patients that the Methodist Hospital is after, I will have 30 pages to talk about.

Dr. **Dorrity**. You want it for 1 month or for a year?

Mr. **Rostenkowski**. The Chair would like to make an observation before this panel withdraws. It is the intention of the Chair to work straight through lunch with panel No. 2. Therefore, if those people in the room on panel No. 3 care to withdraw and go to lunch and be back here by 1:30, you may do so.

Mr. Crane had some more questions of this panel.

Mr. **Crane**. I just have one of Dr. Jahiel. Before that, maybe from our good friend from California I would like to request that when Dr. Dorrity submits that information, if you could disseminate it to the staff so that the full committee might have copies of it——

Mr. **Corman**. I asked it for the record. I think it would be very useful for all the members.

Mr. **Crane**. The only question I had left was something of a philosophical question. You got into the question of health rights and indicated that the fact the people have a right to health care might be misinterpreted. Then you indicate individuals have a right only to the health care that is needed for maintenance or restoration of health. I was wondering how you are defining the word "right" and how you are defining the word "maintenance."

Dr. **Jahiel**. Maintenance includes every aspect of prevention.

Mr. **Crane**. Every aspect of what?

Dr. **Jahiel**. Every aspect of prevention, preventive medicine.

Mr. **Crane**. I am not sure I understand.

Dr. **Jahiel**. Prevention of disease.

Mr. **Crane**. What you mean by "maintenance" then is, in essence, a guarantee of health?

Dr. **Jahiel**. Yes. Prevention of disease through either specific measures given to the individual like a vaccination or general measures which affect the environment. One might even include the social environmental as well as the physical environment.

Mr. Crane. I can think of far-ranging implications of that concept that get into aspects of each individual's personal life. The man who perhaps drinks immoderately or the woman who smokes when she shouldn't be smoking. I am not sure exactly how you go about implementing his right to health maintenance if particularly you are talking about government intrusion.

I know the Surgeon General has put on the pack of cigarettes that it is dangerous to your health. But the person, for example, who engages in any kind of excess, if his right to health maintenance means guaranteed by government is going to be assured, it seems to me that you finally get down into some course of mechanisms that are a little bit horrifying to contemplate.

Dr. Jahiel. Not necessarily. This is one of the most complex questions and it would be difficult to discuss it within just 1 or 2 minutes.

There is the area of making available to that person who smokes services for helping him or her if he so desires to stop smoking.

Mr. Crane. You are not going to impose that maintenance on him. That is his right.

Dr. Jahiel. I don't think that it is necessary. I think it is possible to permit a person to exercise his or her right without imposition upon that person, except in those areas where there is a direct harmful effect upon others, as, for instance, in the case of a contagious disease where there are already some limitations.

Mr. Crane. Would you extend that concept to include a right to maintenance in the area of food, fuel, housing, transportation?

Dr. Jahiel. Again, this is a complex question in which one would probably have to——

Mr. Crane. Let's take food.

Dr. Jahiel. In terms of food, in my own opinion—by the way, I am talking only for myself—I would say that food is a treatment of choice of certain diseases which are specific nutritional diseases. If somebody comes with kwashiorkor or with advanced starvation or——

Mr. Crane. I am not talking necessarily within the context of maintaining that person's health. I mean as a concept. You are talking about a right here and that is a right to health maintenance. I am wondering if you see access to food as a right necessary to maintain basic health, the same with respect to fuel, transportation, and housing.

Dr. Jahiel. This is a complex question which has to be answered with specifications. I was trying to give one example of an instance whether a particular specification was needed. Certainly one could again abuse the right of a patient by including almost everything under the Sun. This is my point.

Mr. Crane. Precisely my point.

Dr. Jahiel. This is my point, too. This right can be specified in such a way as to be most reasonable.

Mr. Crane. I would like to see that sometime. I thank you very much.

Dr. Dorrity. If, for example, medical care is considered right, I don't think it is. Iife, liberty, pursuit of happiness, yes.

Medical care, no. But in the event that this body decides that medical care is a right, if someone does not receive medical care for whatever reason, who has abridged that right and who is liable for abridging this so-called manufactured right, what would be the consequences, and where do you intend to draw the line?

You would have to go into a civilian draft, with all its ramifications, and that is tyranny.

Mr. CRANE. I have one brief remark on that. That is a very significant point you raised, because that is precisely what is happening in Great Britain today where patients are dying because of a government rationing system. This happened while some of us were over, there, in fact.

The question is who has the accountability? I think it is obscured within the bowels of their bureaucracy because when they classify patients on the basis of emergency, or when convenient, at some point when convenient admission becomes early and early becomes an emergency, and a woman died while we were there, went through that progression, who was denied medical care because they were inundated and didn't have the facilities available to treat her, I am sure nobody could be held accountable for that.

Mr. DELANEY. I wanted to speak to Mr. Crane. There is a certain kind of rationing taking place in medical care in our country today. There are a lot of people who die today because they could not get adequate care.

Mr. CRANE. Would you tell me of one?

Mr. DELANEY. I know of cases.

Mr. CRANE. Give me one in Arkansas.

Mr. DELANEY. I can give you an example of Houston, where a woman was not admitted to the hospital who was in labor and died before they could get her to the county house.

Mr. CRANE. Where was this again?

Mr. DELANEY. This was in Houston, Tex.

Mr. CRANE. Do you know the name of the hospital?

Mr. DELANEY. It was a Methodist hospital.

Mr. CRANE. Do you remember the time, what year?

Mr. DELANEY. No, I don't remember exactly the time, but I am saying that lots of people die because they can't get care.

You know that. The Arkansas Health Planning Commission said that half of the population of Arkansas, 2 million people, get less than one-fourth of their health care needs met in any year in Arkansas. I don't think it is any question but health care is rationed in this country. But the system is built in such a way that there is rationing on this delivery of health care and a lot of people die because of this rationing.

Mr. CRANE. You are making a pretty wild generalization about a lot of people dying under the rationing system that exists here through delivery services and payment for services delivered and you will not give me a year of that specific case in Houston, your district.

Mr. ROSTENKOWSKI. Mr. Delaney, would you be able to get that information and submit it to us?

Mr. DELANEY. I could probably get this from cases in Arkansas.

Mr. ROSTENKOWSKI. Why don't you do that. Is there anything else you would like to make a comment on?

[The information was not received in time for publication.]

Mr. ROSTENKOWSKI. I thank you very much. You have been most cooperative and informative.

Thank you very much for joining us this morning.

Mr. Vanik?

Mr. Vanik. Mr. Chairman, I was unable to be here for their testimony, but I would like to express my appreciation to this panel for the fine record they are helping us develop. It will be quite useful in our deliberations.

Mr. Rostenkowski. We will recess for 10 minutes. There is a quorum call going on.

We will recess and return in 10 minutes to hear panel 2's testimony.

[A brief recess was taken.]

PANEL CONSISTING OF SOL BRANDZEL, VICE PRESIDENT, AMALGAMATED CLOTHING WORKERS OF AMERICA, AND CHAIRMAN, ILLINOIS COMMITTEE ON HEALTH SECURITY; ZITA FEARON, CHAIRWOMAN, CONSUMER COUNCIL TO THE NEW YORK CITY DEPARTMENT OF HEALTH; VERNON B. ASTLER, M.D., PRESIDENT, FLORIDA MEDICAL ASSOCIATION; REV. RICHARD BOWYER, CHAIRMAN, WEST VIRGINIA COMMITTEE FOR THE HEALTH SECURITY ACT; BERNARD WILLOW, CHAIRMAN, ILLINOIS PUBLIC ACTION COUNCIL; AND DEBORAH MAYER, NINTH CONGRESSIONAL DISTRICT (ILLINOIS) COMMITTEE ON HEALTH SECURITY

Mr. Rostenkowski. We will resume.

I want to take notice of the fact that there might be some quorum calls where we will have to go into some recesses, but the other committee members assured me they would be back as early as possible.

Whatever the case, we will read your testimony when it is in the record.

So, Mr. Brandzel, if you will, begin your testimony, identify yourself, and proceed.

STATEMENT OF SOL BRANDZEL

Mr. Brandzel. Thank you, Mr. Chairman. My name is Sol Brandzel, and I am vice president of the Amalgamated Clothing Workers of America and the manager of the Midwest regional joint board and the Chicago joint board of the Amalgamated. I am also the president of the Sidney Hillman Health Centre, chairman of the trustees of the Amalgamated Social Benefits Association, and president of the Amalgamated Life & Health Insurance Co. I am also the chairman of the Illinois Committee on Health Security, a coalition of unions, churches, civic groups, senior citizens, health professionals, and individuals.

In view of the inquiry that was made earlier, I would say we are affiliated with the National Health Security Council, and although there are no funds that flow back and forth between that national affiliation and ourselves, we believe basically in their philosophy, and we get information from them which helps us in our work.

With me this morning are Deborah Mayer, chairperson, Ninth Congressional District Health Security Action Coalition, and Bernard Willow, chairman, Eighth Congressional District Health Security Action Coalition.

With your indulgence, at the conclusion of my testimony, I would like each of them to have 2 or 3 minutes to state what is happening with respect to their areas.

Mr. Rostenkowski. If we have the time, we will do that.

Mr. Brandzel. Thank you.

In its statement of principles adopted in May 1974, the Illinois Committee on Health Security called for comprehensive national health legislation that would: (1) be universal in coverage, (2) be comprehensive, covering all services, (3) encourage preventive medicine, (4) be progressively financed, (5) have strong cost-controls, (6) have strong national quality standards, (7) provide for increased health personnel and (8) provide for the development of new resources and programs.

Today I want to speak to you both as a union leader and as chairman of the Illinois Committee on Health Security.

Recently, in a panel discussion on national health insurance, someone asked me, "Why are the unions pushing national health insurance so hard, you fellows really don't need it, most of your members are already covered by good comprehensive health insurance policies?" This question represents a widely held misunderstanding of the problem of most workers who are covered by insurance. For even though many people have, as we do in the Amalgamated Clothing Workers, extremely comprehensive private health insurance with benefits and premium paid for by employers as a result of collective bargaining negotiations, several major problems in the health delivery system in the United States bear very heavily on working people. First of all, enormous cost increases mean that every time we negotiate new contracts we must negotiate more money from the employer merely to retain the benefits we already have, and on the bread and butter issues for which we originally organized. In addition, many private insurance policies have loopholes, deductions, coinsurance, exclusions, time limits, dollar limits, and a whole series of limiting clauses which increases the individual's financial liability for health care.

Insurance often does not cover patient-initiated doctor visits, or the first dollar of many medical services. Thus, in addition to high premiums, which for many workers are equivalent to 1 month's salary a year, out-of-pocket costs for workers who have insurance may amount to several hundred dollars for routine, nonhospital medical services. Needless to say, this cost is a barrier to preventive health care. It may amount to 1 month's salary. In addition, millions of Americans have no coverage at all and continuing high unemployment increases these numbers.

Another problem is that millions of Americans from all walks of life can't find a doctor when they need one. According to a recent article in the Wall Street Journal, for example, the number of family practitioners has dropped to about 52,000 from 67,500 a decade ago, and to almost half the number that was in practice in 1930.

"There's no question about the deficiency in primary care in the United States," said Dr. Charles A. Janeway of the Pediatrics Department of Children's Hospital Medical Center in Boston. "It is evident in the crowded emergency rooms of urban hospitals with their flood of patients seeking care for ordinary illnesses, in rural areas totally without physicians, and even in suburbia, where finding a doctor to care for the family or to deal with an unexpected illness at an inconvenient time is often impossible," he notes in a recent article on family medicine in the New England Journal of Medicine.

We also feel that it is very difficult to get the high quality medical care that our members and all Americans are entitled to. There are no national standards for retraining or continuing education among physicians, for example, although many other professions feel this is essential. A physician has a license for life.

Unions want strong cost-controls in any national health insurance legislation, high national quality standards, and an increase in the personnel available to provide health care. These things are uppermost in the minds of union members and union officers who negotiate collective bargaining agreements.

I also want to relate to the committee some of the response that our committee has been getting from citizens throughout the State of Illinois. The Illinois Committee on Health Security has a steering committee of 50 individuals and organizations and has active groups working in 18 congressional districts throughout the State. These groups are conducting educational activities sponsoring forums and seminars and speaking to retirees' groups, and others, PTAs, nurses, social workers, trade unions, and other gatherings of citizens, many times on panels with AMA–AHA, and insurance industry spokespersons. One of the things that stands out in virtually all of these meetings is that most people feel that the private insurance industry has not done a good job of protecting people from the financial liability of health care. High and ever increasing premiums do not guarantee coverage. Many vital services are not covered at all and in the handling of claims, many people complain of bureaucracy, redtape, arbitrary denial of claims, lack of an appeal process, lack of sympathetic hearing of people's problems, and undue delays in handling claims. These complaints apply with equal frequency to Blue Cross and Blue Shield, as well as to the rest of the insurance industry.

Some people, including several Senators and Congressmen, have come down on the side of catastrophic health insurance. Catastrophic insurance is not the answer to America's complex and interrelated health care problems. Financing of health care is obviously one problem factor in the health delivery system. Delivery, personnel, accessibility, and other factors are equally important. Catastrophic insurance focuses on long-term high-cost hospital stays, but diverts attention from the basic dilemmas of our health care system. The escalating costs, shortages of personnel, uneven quality, and the other factors that I have mentioned must be dealt with in any national health insurance bill. Any bill that does not deal in a strong comprehensive fashion, with all of the interrelated problems and issues in health delivery, is doomed to only making matters worse. A catastrophic bill would undoubtedly be an additional inflationary pressure on the cost of health care while doing little or nothing for quality standards, personnel, resource development, preventive medicine, and the other issues that are so important.

It is a pleasure actually for me to be here before this committee, because I think this is one place where I don't have to explain that a comprehensive national health insurance bill, like the H.R. 21, would not cost any more in the total amount than the amount that we are now spending on health care or the amount that is called for by the AMA bill or the insurance industry bill or the Long-Ribicoff bill. With most groups, this is one of the basic facts that you have to explain before you can go on to the other issues. The AMA and other opponents of comprehensive national health care have done their job very well of convincing some people in the United States that our country cannot afford to provide good health care for all its citizens. I think that you ladies and gentlemen on the health subcommittee must be aware more than anyone else in the country that this is not the case. It is not really a question of can we afford it, the only question really is, can we afford not to do it because of escalating costs?

In 1974 we were talking about a medical health care cost of $104 to $150 billion. It is estimated that in 1975 we are going to be talking about $118 billion.

The real issue is whether we have the will to establish such a program; do we want to make sure that all Americans are entitled to health care on an equal basis regardless of how much money they have in their pockets at any particular time. This is really the question that you are going to be dealing with, and I am confident that you will come up with an answer in the form of health legislation that is reasonable, just, and meets the needs of all Americans.

I would like to remind you, if I may, that we would have an opportunity to hear the other two people here from the Eighth and Ninth Congressional Districts.

Mr. ROSTENKOWSKI. Thank you, Mr. Brandzel.

Dr. Astler?

STATEMENT OF VERNON B. ASTLER, M.D.

Dr. ASTLER. Mr. Chairman, and committee members, my name is Vernon B. Astler. I am a fourth generation physician, practicing general and vascular surgery in Delray Beach, Fla. I have received my training at Miami University, Temple University Medical School, and the University of Michigan Graduate School. I have served 2 years overseas as a captain in the U.S. Army Medical Corps; in Korea and Japan during the Korean conflict. I am currently president of the Florida Medical Association and represent over 10,000 physician members of this association.

I am honored to have been asked to appear before this most important committee. I am here to encourage you to oppose any proposed sweeping national health insurance program modeled after the State-supported schemes of Europe and exemplified by the Kennedy-Corman plan [S. 3, H.R. 21] which bears striking similarity to the British system.

I shall try to explain why such a sweeping national health system should be opposed based upon logical analysis of fact and figures. Our national health spending in 1973 was $94.1 billion for health, or $441 per person, up 10 percent over the previous year. If we were to analyze per capita health expenditures by the year, we would see that in 1950 we spent approximately $78 per person or 4.6 percent of the gross national product. By 1960, $141 or 5.2 percent of the gross national product and by 1973, $441 or 7.7 percent of the gross national product.

The economic hardship created by a national health care system simply cannot be borne by our workers and producers. I feel that health care delivery in the United States is related in a general way to other problems facing our country. Problems such as unemployment, high jury awards, the increased cost-of-living, inflation, the national debt, standards of luxury unimagined 20 years ago, food stamps, the oil crisis, the drug problem, and immorality, just to mention a few. It is my feeling that these problems are influenced in this age of meliorism by permissiveness in our society, the welfare syndrome, and by diminished demand for individual responsibility. As we reflect on figures concerning Government spending, I think it is not surprising that costs have also risen in a similar way in the field of health care.

Government spending in the United States this year will reach over one-half trillion dollars. A trillion is one thousand billion or a million million dollars. This amount is twice that our Government spent in 1967 and over 25 times the amount spent in 1940. If we divide this one-half trillion figure by the number of households in the United States, estimated at 71 million in January of 1975, this works out to a total Government expenditure per household of almost $7.792 or more than double the figure of $3,392 per household spent as recently as 1965. Now, we are hearing again the outcries for a Federal program for financing health care for all our citizens. A sweeping program to replace the free enterprise system which has been delivering in this country. A health system which covered 160 million people in this country under private medical insurance plans when medicare began in 1967 and covered over 181 million by 1971. Today, medicare covers only 10 percent of our total population and yet costs the same as insuring the other 90 percent ($14.7 versus $14.8 billion expended in 1971).

I will not argue the comparison since the 65 plus age group carries a higher risk of illness, but certainly it is not nine times greater. Many of you will remember that before medicare was enacted in 1967, the Government actuaries insisted this program would cost a mere $1.6 billion in 1975. But by 1974 the cost was already nine times that much more than $14 billion.

Let us analyze these costs and let us look at the giant Department of Health, Education, and Welfare. This Department is spending almost twice as much each year as the "after tax" profits from all corporations in the United States. If all corporate profits plus all personal savings of United States citizens were confiscated by the Federal Government, the money would run the Department of HEW for only about 14 months. This swollen, overgrown, giant Department now spends more than $118.4 million a year, more than any other department, including the Department of Defense. Incidentally, that is more money than was spent by the entire U.S. Government in 1960. Now how would a sweeping national health insurance program affect these costs?

A brief review of political medicine and national health schemes in Great Britain and Sweden clearly predict the course one could logically expect with a similar national health scheme in the United States. In Great Britain over one-half million people await hospitalization and there is up to a 2½-year wait for elective surgery. Medical doctors have fled the country in great numbers and been replaced in substantial part by physicians migrating from India.

In Sweden, the costs have risen ninefold since the onset of the system in 1960. A Swedish family of four, earning 50,000 kroner a year [about 12,500 U.S. dollars] pays 55 percent of their income in taxes as compared to 20 percent for a comparable U.S. family of four in a similar income bracket. There are no beds available in Stockholm and 4,000 people in that city await hospital admission and 1,000 await surgery.

Let us consider the physician shortage, even the Department of Health, Education, and Welfare is retreating somewhat from their former concerns. Former Assistant Secretary of Health Charles C. Edwards expressed belief recently that we may be heading for a glut of health professionals. If the United States merely maintains the current output of health professionals in our present institutions, by 1985 we will have 50 percent more physicians, 40 percent more dentists, and 60 percent more registered nurses than we had in 1970. This does not take into consideration the marked influx of foreign medical graduates. Yes; we hear of the doctor shortage and yet the physician population has grown 33.6 percent since 1964, while the overall U.S. population is up 9.1 percent.

I would say it would be foolhardy to embark on a major overhaul of the health care system considering the fact that over 181 million Americans have at least one private health insurance policy and 74 million Americans have comprehensive major medical policies. If we add the 24 million actual recipients of medicaid and medicare we see that over 90 percent of the American people are presently covered by some health care coverage. In a recent nationwide poll, Americans were asked to rate 16 listed concerns in their order of importance. It was of interest that inflation and Government spending were 1 and 2, whereas health care was listed 15th in the poll.

Where are the areas of need? First, catastrophic insurance is essential, for none of us can afford a catastrophic illness such as a stroke, crushed pelvis, or a massive and disabling heart attack. Actuaries have estimated that if catastrophic insurance coverage were offered to and accepted by every American the cost would be a mere $50 per family per year and less than $25 per year per individual. I might add that the thought of consumer abuse for catastrophic health insurance does not concern me since most folks are not going to go out and have a catastrophic illness merely to collect on their insurance. However, abuse certainly would result if our Government were to offer first dollar health care coverage for all citizens. Under such a system the worried well would clog the health care facilities in our country. I am alluding to those who are not truly ill, but simply suspect they are, or are usurping the benefits of the system because it is offered at Government expense.

Second, I think, care to the unemployed, the physically handicapped and the self-employed should be a matter of national concern. I do not feel the health insurance industry or the health providers could or should assume the cost for these truly noteworthy categories.

Third, Federal assistance for health is needed for the 10 to 15 percent of our population for whom the barrier is truly cost. It is possible to provide mainstream health care to most disadvantaged people by introducing them into the mainstream. It is not necessary to move or totally disrupt the mainstream. The two keywords dominating the successful operation of our system are access and mainstream. Many people lack access to the mainstream health care, either from lack of education or lack of personal initiative to seek it. Here greater emphasis on health care education is needed, others need access because of matters of geography or cost.

Fourth, the problem of rural health care is substantial, but should be dealt with separately. The number of people here are small and the geography is vast.

Fewer than 3 percent of our population reside more than 20 miles from some medical facility. It is likely that a transportation system has more to offer these people than redistribution of medical personnel or construction of more and costly health facilities.

Lastly, I would like to say a word about nursing homes for I feel some changes are necessary. Most of our nursing home facilities offer one standard class of care. This concept decidedly needs updating. Just as we grade patient care in hospitals, the same graded care should be available for nursing home patients. Those with serious strokes, terminal cancer, pulmonary or kidney disease should be separated from others and should pay a price commensurate with the type of care rendered. Others who are merely unwanted by the family or without relatives, who are able as ambulatory patients to dress, bathe, and eat by themselves should be offered domicilliary care. This type of care we offered in years past in so-called rest homes, instead of nursing homes, we called it rest home care.

Of course, the cost of care for these individuals must be in a much more realistice price range and they must be separated from those who are seriously ill.

In summary, I would say that Americans have access to the finest medical care in the world. Our system of essentially private free enterprise health delivery has its failings to be sure, but it is infinitely superior to the State-supported schemes of Europe. Let us make changes in a thoughtful and sensible way, but not embark on a major overhaul of a health care system which is delivering. I would like to close by reading 10 rules of conduct for individuals and Nations.

1. You cannot bring about prosperity by discouraging thrift.
2. You cannot strengthen the weak by weakening the strong.
3. You cannot help small men by tearing down big men.
4. You cannot help the wage earner by pulling down the wage payer.
5. You cannot further the brotherhood of man by encouraging class hatred.
6. You cannot help the poor by destroying the rich.
7. You cannot establish sound security on borrowed money.
8. You cannot keep out of trouble by spending more than you earn.
9. You cannot build character and courage by taking away man's initiative and independence.
10. You cannot help permanently by doing for them what they could and should do for themselves.

These words were spoken by Abraham Lincoln.

Thank you for your attention and the privilege of sharing these thoughts.

Mr. Rostenkowski. Thank you, Doctor.

Reverend Bowyer, Mrs. Mayer.

STATEMENT OF DEBORAH MAYER

Ms. MAYER. My name is Deborah Mayer, and I am testifying as the chairperson of the 9th Congressional District Committee on Health Security. I wish to thank the subcommittee for being so gracious as to hear my testimony, and may I request, Mr. Chairman, that the full written statement as well as the monography on delivery of health care for public aid recipients appear in the record. May I ask that the full written statement as well as monograph appear in the record?

Mr. ROSTENKOWSKI. The monograph and your statement will be in the record.

Ms. MAYER. Thank you.

I shall address the problems of inaccessibility of health care services and lack of preventive care programs.

The 9th Congressional District of Illinois faces the problem of uneven distribution of health resources and services:

Example: Within two to six blocks of my home there are two medical centers, west of this area there are virtually no hospitals. As a result of this condition, hospital facilities are being underutilized in the more affluent sections of the district, while the need for services remains high in the poorer areas of the district where the available facilities are taxed beyond their capacity.

Another kind of accessibility problem is the inability of those who are ill to reach appropriate facilities for lack of transportation. This is a recurrent problem of the public aid recipient.

Example: An 8-year-old child with multiple handicaps was being treated in the outpaient department of a children's hospital and needed cab transportation. The mother had to stand outside her apartment building holding the child, waiting sometimes in vain for the public aid cab to take her to the hospital. Service was so unreliable and the experience so devastating that the mother eventually placed her child in a residential setting.[1]

The cab service is requested only when a patient is sick and unable to use public transportation. Patients suffering from cancer who receive daily radiation treatments, patients on renal dialysis, aged or infirm recipients are dependent on a system which compounds their problems by hindering the provision of adequate medical care. Many in their anxiety or because they are too sick to wait or too disabled to travel, use money needed for rent or food to come by cab. Others without the money or perhaps lacking the stamina required to get service fail to keep vital appointments.[2]

Another problem caused by uneven distribution of services is the prolonged wait for a service to be rendered.

Access is also denied because of de facto discrimination due to age, sex, income level, race or ethnicity. It is a known fact that some patients are refused service at the nearest hospital facility, and instead are sent on to Cook County Hospital [3] for care.

May I just note here now that the residents and interns of Cook County Hospital are on strike, which means that the population that would normally use that facility is again denied access, even though no hospital can legally deny services because the patient lacks income or insurance.

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[1] Sheila Mahtesian and Steven O'Brien, "Delivery of Health Care to Public Aid Recipients." NASW, Ill. Federation of NASE Chapters, December 1974, p. 11.

[2] Loc. cit.

[3] Currently Cook County Hospital Interns and Residents are on strike. Services are cut back drastically. Thus, many are unable to obtain health care services.

One way to remedy the problem of access is to put the services closer to the people: establish neighborhood clinics, encourage group medical practices in those areas lacking the needed health facilities and skilled personnel, and offer diagnostic tests in community clinics. The Kennedy-Corman bill provides financial incentives for the aforementioned services. A further aid would be to have an office available to speak for and assist those in need of services. This is usually part of the functions of a social worker, who is employed by the health facility. But not all facilities have social workers on the premises. Hence in those circumstances, the sick, aged, confused, or handicapped persons facing the complex hospital system do not have such assistance.

The second problem I will address is the lack of preventive care programs. Prevention and detection spell success for most medical programs. That is to say, a problem is attacked before it becomes a crisis, be it physically, financially, or emotionally. Examples of such programs are: physicals for pre-school-age children, vaccinations and inoculations of children and adults, prenatal care, yearly physicals and diagnostic tests for adults, et cetera. The Kennedy-Corman bill encourages preventive care by providing for coverage of the full range of personal health care needs.

For example, the 49th ward of Chicago [part of the Ninth Congressional District], they recently ran into a multitude of problems when trying to establish a program of health care to children of preschool age, because no machinery existed to reach this important and vulnerable segment of the population.

In conclusion, change of the current system is necessary to equalize the delivery of health care and remove the traditional barriers to access caused by lack of facilities, lack of personnel, or discrimination, thereby making health care a right, not a privilege.

Thank you.

[The monograph follows:]

THE DELIVERY OF HEALTH CARE FOR PUBLIC AID RECIPIENTS

Prepared by The Public Aid Medical Programs Committee of The Medical and Health Council, Chicago Area Chapter of The National Association of Social Workers

(By: Sheila Mahtesian, A.C.S.W., Chairperson, Public Aid Medical Programs Committee, University of Chicago Hospitals and Clinics; Paul Lehman, School of Social Service Administration, University of Chicago; Steve O'Brien, Chicago Child Care Society)

SUMMARY

The current programs of financial assistance, medical care, and supportive services for Illinois Department of Public Aid recipients are totally inadequate to meet the needs of sick, aged or handicapped individuals. The major inadequacies of the existing program are:

1. They do not provide the financial assistance necessary for maintaining an adequate standards of living.
2. Eligibility requirements for financial assistance, medical care and supportive services are restrictive and disqualify many who are in urgent need of such assistance.
3. The current administration of the programs is characterized by confusion and chaos, which results in poor delivery of service.

4. The current system fails to provide a full comprehensive range of medical and supportive social services.

Recipients, social workers, and physicians experience increasing frustration over short sighted public aid policies which mitigate against the practice of good medicine. During the past year, the number of sick receipients known to social agencies and seeking help from social workers with problems relative to Public Aid has increased markedly. Hospital social workers with problems relative to Public Aid has increased markedly. Hospital social workers and others concerned with the care of the sick are forced to spend an inordinate amount of time attempting to obtain the vital services to which the receipients are entitled. It would be difficult to estimate the number of sick recipients who fail to receive the care required for want of advocates to intervene on their behalf. This is a tragic and self defeating situation, since current policies and procedures affect most adversely the receipient population least able to combat the present system.

THE DELIVERY OF HEALTH CARE FOR PUBLIC AID RECIPIENTS

INTRODUCTION

The relationship between poverty and ill health—both physical and mental—has long been recognized. Increasing evidence suggests that the vicious cycle characterized by poverty and illness, has endangered great numbers of the nation's poor.[1] A vital aspect of this problem which has failed to receive much needed attention is how the current financial and medical programs of public assistance in Illinois could be made more humane and responsive to the health needs of their recipients.

This report is an initial effort to call urgent attention to the impact of current public aid policies and practices on the quality of health care. It is our impression that the administration of financial and medical programs of public assistance in Illinois are in a state of chaos, in which poor people—especially those who are ill—are victimized. Recent changes in Public Aid and Social Security legislation[2] and the absence of precise guidelines have hindered the delivery of effective service. These two factors have caused hardship and stress for many of the sick, aged, and handicapped who lack the resilience, the mobility, and the physical endurance to combat the present system. It is a system which fails to provide the financial assistance necessary for maintaining an adequate standard of living with supportive services necessary to meet special needs, and has been characterized by a marked deterioration in the quality of services delivered in the past year.

Social service personnel and other concerned citizens share the frustration experienced by public aid recipients. Social workers in hospitals and a variety of social welfare agencies are receiving increasing numbers of requests from public aid recipients who have been frustrated in their own attempts to obtain assistance from the Illinois Department of Public Aid (I.D.P.A.). Case examples from various social service departments of private hospitals in the Chicago area contained in this report illustrate the frustration experienced by recipients and the barrier the present system presents to the practice of good medicine. It should be noted that the magnitude of the problem cited in this report cannot be underestimated because many public aid recipients use the services of physicians in private practice. Many of these recipients are encountering problems similar to situations discussed in this report, but do not have a social worker to document their problems or to assist them in their struggle to obtain financial assistance or special services for which they may be in urgent need.

This report consists of six sections and an appendix. The first five sections contain discussion and case material illustrating current problems regarding:

I. Supplemental Security Income (S.S.I.).
II. Illinois Consolidated Standard Plan (I.C.S.P.).
III. General Assistance (G.A.).
IV. Food Stamps, Medical Assistance No Grant Program (MA–NG).
V. Administrative and Inter-agency Confusion.

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[1] For example, in the well-known Chicago Poverty Study by Lepper and Lashaf, health data presented confirmed significant differences between poverty and non-poverty populations. Their findings suggested that infant mortality rates of poverty populations were 75% higher than those of non-poverty populations, and that post neo-natal mortality rates in poverty areas were more than double the rates in non-poverty areas.

[2] See Appendix for further information on recent changes in Public Aid and Social Security legislation.

Specific recommendations regarding improvements in the provision of services are included at the end of each of these five sections. General recommendations are contained in Section VI. The Appendix contains background information on the S.S.I., I.C.S.P., and G.A. Programs.

Section I.—The Supplemental Security Income Program

Although the S.S.I. Program is administered and funded by the federal government, the State of Illinois continues to be responsible for the provision of medical care and social services to S.S.I. recipients. The state is also responsible for establishing eligibility guidelines and evaluating the need of S.S.I. recipients for medical and social services.

In the first year of operation, major problems have arisen regarding the S.S.I. program and the State's role in providing medical care, supportive social services, and/or financial supplementation to eligible S.S.I. recipients. The major problems include: (a) Delays in processing of S.S.I. applications and the means by which G.A. is provided pending determination of eligibility. (b) The restrictive nature of the eligibility requirements utlzed by Illinois in the provision of social services which makes individuals with incomes of more than $146.00 a month and couples with incomes of more than $219.00 a month (plus minor income disregard for both individuals and couples) ineligible for services though they may be aged, blind, or disabled. (c) Problems related to the federal government's determination of disability, and the process previously utilized by the I.D.P.A. in the administration of their A.A.B.D. Programs. (d) Confusion in providing state supplemental checks to S.S.I. recipients and (e) Limitations of emergency assistance.

A. Currently the processing of S.S.I. applications takes from four to six months, during which time qualified S.S.I. applicants can receive G.A. and medical care benefits. This has caused much hardship since S.S.I. applicants are aged, blind, or disabled and cannot tolerate the stress of a monthly trip to a public aid office to reapply for G.A. Medical benefits for G.A. recipients with S.S.I. applications pending are more limited than those offered subsequently to S.S.I. recipients. This policy has resulted in the denial of certain medical services to G.A. patients at the time when they may be most urgently needed, such as following the onset of a catastrophic illness or after an extensive injury.

Example A1.—A steadily employed man suffering from widespread cancer had to stop work in September 1973. He applied for Social Security Disability benefits and S.S.I. in November 1973. His original application for Social Security was denied. An appeal to the Federal Review Board resulted in his application being approved in August 1974.

The patient was a G.A. recipient while eligibility for disability was being established. This entailed a visit to the Social Security Office each month to secure verification that his case was being processed, followed by reapplication at his local Public Aid office for G.A. and his medical card. Sick patients often report being 80th or 90th in line and having to return the following day. This patient maintained that he seldom received his medical card "without a hassle", a humiliating and frightening experience since his medication alone, vital for the treatment of his cancer, cost nearly $100.00 per month. His food allowance as a G.A. recipient at that time was $1.07 per day, or $32.44 per month.

Example A2.—A 40 year old diabetic who had worked as a clerk for 10 years for a large chain store developed problems in controlling frequent hypoglycemic episodes. He was hospitalized 3 times in the past year and was eventually forced to quite his job. He applied for S.S.I. in January 1974, but was denied disability benefits. He has since has numerous epileptic seizures, and further medical information is currently being reviewed by the Federal Disability Board. In the meantime the patient is receiving G.A. As a G.A. recipient he has a current food allowance of less than $1.25 a day.

B. The restrictive nature of the State of Illinois' eligibility requirements for supportive social services has created serious problems. Illinois currently utilizes a monthly ceiling of $146.00 for an individual and $219.00 for a couple as maximum allowable income in determining eligibility for social services. Despite a $20.00 S.S.I. income disregard (which does not apply to Veterans' benefits), the present eligibility level denies many aged, blind, and disabled persons the right to vital supportive services, such as homemaker service, because their income exceeds the ceiling by a few dollars.

Many individuals receiving Social Security benefits are facing the prospect of a sheltered care or nursing home facility because their assets and/or income make them ineligible for S.S.I. and homemaking services. They have insufficient income to employ a homemaker privately and homemaker agencies in the community are unable to provide this service on a regular basis. The rigidity of this policy is short sighted, since the cost of nursing home care could be 3 to 4 times the cost of a supportive homemaker or housekeeping service to maintain a patient in his own home.

Example B1.—A 72 year-old widower who suffers from a serious neurological problem resulting in progressive weakness of all muscles was able, despite his disability, to remain in his own home with the provision of supportive services. These have included household help 3 hours per day to take care of shopping, cooking, and cleaning.

The patient's income is $175.00 per month from Social Security benefits. When his case was reviewed in September 1974, his income was found to be over the S.S.I. standard of $146.00 per month. His allowances from Public Aid and S.S.I. were stopped, and he can no longer pay for the help that is essential if he is to remain as he wishes, independent and in his own home. The cost of household help is $1.65 per hour, or less than $100.00 per month. Care in a nursing home could cost $600-$700 per month.

Example B2.—A 54 year-old MA–NG recipient with metastatic breast cancer was hospitalized recently for treatment of a hip fracture. On discharge, she required temporary homemaker help. Her only source of income consisted of Social Security benefits of $175.00 per month. This was above the income allowance of $146.00 for S.S.I. benefits, and she was not eligible for supportive services. As a MA–NG recipient, she was ineligible for homemaker help, since this is not regarded as a medical service by the Department of Public Aid. It would have been possible to place this patient temporarily in a nursing home through the Department of Public Aid, where the cost might be $500–$600 per month. It was not medically essential, however, and she wished to return to her own home.

This woman represents a high proportion of patients who could be adequately cared for in the community if they were eligible for supportive services through S.S.I. or the MA–NG program.

Example B3.—A 74 year-old patient who lives alone was hospitalized in April 1974 for a month, during which time a below-the-knee amputation was performed. Homemaker help was recommended on discharge pending the fitting of an artificial limb—usually about 6 weeks later. The MA–NG application was approved but the patient was above income allowance for S.S.I. benefits and subsequently for homemaker services. As a MA–NG recipient, she was not eligible for homemaker help.

It is rare that a community agency can offer this type of service to the elderly. Priority for homemakers is given to mothers with young children. This patient, who could have been discharged to her own home with adequate help and who wanted to return home, was eventually sent to a rehabilitation hospital for a month where the cost of care was $150.00 per day, or approximately $4,500 per month. Homemakers are paid $1.65 per hour by I.D.P.A.

C. The present system, in which recipients are dependent upon the federal determination of disability, has resulted in cumbersome procedures which lend themselves to computer or human error. Despite guidelines which permit a closer working relationship between the State and federal agencies, there is little evidence that State and federal agencies are working in a spirit of cooperation to bridge the gaps in service which currently exist.

When it is necessary for a patient to apply for "permanent and total disability", significant problems present themselves. (1) A patient who faces long-term illness, and who is unready psychologically to accept the extent of his incapacity, must apply for S.S.I. if he is to receive benefits from I.D.P.A. (2) Patients may be severely disabled and in need of more service than can be provided through G.A. They may be expected to recover within a year, however, and therefore be ineligible for disability benefits.

Example C1.—A 55 year-old Public Aid recipient who suffers from multiple problems which include heart disease, hypertension, gastric ulcers, and depression was referred with a medical report to her local Social Security Office in April 1974. A request from the State of Illinois Federal Disability Program for medical information was received 6/26/74. A report was mailed by the Hospital medical record department 7/8/74. On 7/23/74, the patient was informed by the Federal Disability Program that her case might be denied for lack of proof of disability since no medical information had been received. Despite immediate contact with Springfield, the patient was informed by the Bureau of Disability Insurance, Baltimore on 8/18/74: "After carefully studying your records, including the medical evidence and your statements, and considering your age, education, training and experience, it has been determined that your condition is not disabling within the meaning of the law".

A call to Springfield revealed the following information: (1) The original report to the local Social Security office had never been forwarded to Springfield. (2) The report of 7/8/74 was presumed to be "back logged in the mailroom". (3) The claim had been denied for lack of information rather than for denial of disability. This case is pertinent to our concern over current Public Aid procedures and their impact on health care since the State and federal programs are so closely interrelated, and it is the federal determination of disability which is accepted by I.D.P.A. In this instance, the case was reopened; but many patients receiving care from local physicians, for example, would not have a social worker or other agent to intercede on their behalf. The case is also significant because it represents not only the breakdown in communication between local Social Security offices and the Federal Disability Program in Springfield, but illustrates the need for a closer working relationship between I.D.P.A. and Social Security. This patient's local Public Aid office was also sent a medical report (DPA 126h) in April 1974.

Example C2.—A 30 year-old man was hospitalized following an accident and is now quadruplegic. Initially a G.A. recipient, he had to apply for disability medical assistance through S.S.I. This involved discussion, with the seriously depressed patient of a program designed for the "permanently and totally disabled". The S.S.I. definition of disability states: "the individual must be unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months". Prior to 1/1/74, receipt of disability assistance through I.D.P.A. would have required only the completion of form 126h by the patient's own physician without the necessity for the patient to confront reality at a time that is psychologically inappropriate. A period of 6 months of anticipated disability, with appropriate medical evidence, would have met the former requirement for I.D.P.A. disability benefits.

This case also exemplified the problem of interagency confusion over procedure at the local level: (1) The G.A. worker felt the Intake Unit worker should take the D.A. application. (2) The intake supervisor maintained that the D.A. application could not be taken until S.S.I. was approved. (3) The medical rehabilitation worker suggested that she might be able to come to the hospital to take the application, but was unsure of current agency policy regarding hospital visits.

D. A guideline relating to the implementation of the S.S.I. Program required that no individual receiving A.A.B.D. funds as of 12/1/73 should receive any less money under the new S.S.I. Program. Therefore, states were required to supplement those individuals or couples whose grants under the S.S.I. program would be less than they had received under A.A.B.D. Some confusion has been evident in the course of S.S.I.'s first year regarding this supplemental payment. Initially, those individuals who required a supplement and were active A.A.B.D. recipients as of 12/31/74 received one check from the federal government which included the state supplement. Those individuals applying for S.S.I. after 1/1/74 who qualified for the state supplement had to file at the I.D.P.A. and would then receive two checks, one from the federal government and one from the state. Since October 1, 1974, individuals receiving the state supplement have received two such checks. This change created anxiety and confusion for many S.S.I. recipients who received inadequate notice from S.S.I. and I.D.P.A. about the pending change in procedure.

When the letter regarding the change was received, many S.S.I. recipients did not understand the communication and had difficulty when they attempted to reach a worker at Public Aid or at Social Security for clarification. There is also concern because both checks are no longer received at the beginning of the month—a system which previously permitted payment of rent and purchase of the full value of food stamps to which recipients are entitled.

Example D.—A 34 year-old P.A. recipient with a good past work record, has become severely incapacitated during the past year by pulmonary hypertension, congestive heart failure and depression. She has required 4 periods of hospitalization since October 1973 and 2 months in a psychiatric day care program.

The patient became acutely disturbed 9/15/74 when she received a letter from S.S.I. indicating that here benefits would be cut from $177 to $146. A telephone call to Social Security resulted in a recorded message suggesting she call later in the day. She was unable to reach her Public Aid worker and panicked over her inability to pay rent and survive on $146.00. (This problem of inaccessibility of staff is critical for recipients.)

Her anxieties were compounded by earlier difficulties with Public Aid. She had moved in July 1974, following a fire in her apartment building. The new address had been given promptly to her social worker, but mail continued to be sent to her old address. For four months, this sick woman had to make monthly trips to her local Public Aid office, to wait in line to complete necessary forms and pick up her check, food stamps, and medical card.

Through her hospital social worker, the patient eventually learned that she would receive a check from the State each month for $31.00. This check was also sent to the old address, however, and it was not until the 5th month after her move that she finally received in the mail and at the correct address, her medical card, food stamps, and State supplement.

This patient, who has significant physical and emotional problems, typifies many recipients who were confused and alarmed by the change in S.S.I. benefits and could obtain no immediate clarification from a Social Security or Public Aid worker. She also represents the large recipient population who are the victims of human or computer error and whose problems, both physical and emotional, are compounded by environmental stress.

E. The absence of clear guidelines for the provision of emergency assistance for S.S.I. recipients has created additional hardship. Currently, the Social Security Administration only provides emergency assistance for the S.S.I. applicant at the time of application if the applicant is found to be presumptively eligible for S.S.I. and is in emergent need of food or housing. The S.S.I. applicant can then receive up to $100.000, which will later be deducted from his or her S.S.I. check.

Example E.—A 50 year-old 74 pound Public Aid recipient who suffers from multiple congenital problems, including a cleft palate and a gastro-intestinal abnormality which results in a severe form of malnutrition, had none the less taken pride in managing her Public Aid budget and never falling into arrears with her rent and other vital payments. Following the switch to S.S.I., she failed to receive her S.S.I. checks for 3 months, due to computer error. During this time, there was frequent communication with S.S.I. in Springfield and with her local Public Aid office. It was eventually possible to get emergency payments for this woman, but not before she had received an eviction notice and had been threatened with the cut off of utility services. It was not possible during the 4 months of computer chaos to get any help through her local Public Aid office. Her special dietary requirements precluded the provision of food from a community kitchen and her speech impairment made it impossible for her to clarify her own needs.

Recommendations.—1. The I.D.P.A. should take measures to encourage independent living by liberalizing its eligibility requirements for supportive social services, particularly in relation to the provision of homemakers and housekeeping services. This would prevent the forced entry of many aged, blind, and disabled persons into nursing homes because they currently do not qualify for supportive services. It is also essential that equipment vital for a patient's rehabilitation, or for an integral part of his total care, be provided without delay. This would include walkers, wheelchairs, and essential home nursing equipment.

2. In order to facilitate faster processing of G.A. applications for S.S.I. applicants, and to ease the burden of multiple trips involved in the current application process, outposts should be established by the Department of Social Security for the purpose of accepting G.A. applications. There should also be a closer working relationship between state and federal workers at a local level. Additional liaison staff with some understanding of medical problems is needed to ensure prompt and effective service for sick recipients.

3. The I.D.P.A. and Social Security Administration should develop a comprehensive emergency assistance program for S.S.I. recipients.

4. State supplement checks, food stamps, and medical cards should be sent to eligible recipients at the same time the S.S.I. checks are issued by the federal government. Also many elderly recipients or those with visual problems have difficulty with the similarity in the color of checks, medical cards, and I.D. cards. Some differentiation in color would be helpful and lessen current confusion.

Section II.—The Illinois Consolidated Standard Plan

On 10/1/73, the I.D.P.A. implemented the Illinois Consolidated Standard Plan—a flat grant program for providing assistance to ADC/ADC-U recipient families. In the course of its first year of operation major problems have arisen relating to the adequacy and administration of the program. Significant problems include: (a) The absence of special allowances for recipients, in recognition of special needs—especially the needs of recipients with health problems. (b) Lack of clarity regarding the provision of special allowances or items obtainable by vendor payment and the poor quality in the delivery of such services. (c) Inadequate provisions of the emergency assistance program. (d) Long delays in the replacement of lost or stolen checks, food stamps and in the correction of computer errors, and (e) Delays inherent in the new Intake System.

A. Many concerned individuals and groups feel that I.C.S.P. fails to provide adequately for many recipient families. The plan also fails to recognize the unique needs and expenses of families with health problems. Under the former program of ADC/ADC-U, special allowances were granted to recipient families to meet medical needs such as dietary allowances for patients suffering from diabetes, anemia or gastric ulcers and special allowances during pregnancy to ensure adequate nutrition of a mother and child. It was also possible in the case of serious illness and with appropriate medical documentation, to have telephone service provided to ensure immediate contact in times of crisis, and to give a mother guidance for example, in the management of a child with chronic health problems. Allowances were available for the newborn to provide cribs, clothing and the necessities to prevent illness in early infancy. Carfare could be obtained for children requiring it for school or for medical appointments.

Example A1—Telephone.—A 26 year-old mother of 5 dependent children suffers from acute leukemia. She is critically ill and requires frequent hospitalizations in addition to close observation in the outpatient clinc. Because of the severity of her medical condition, the provision of a telephone has been requested. As a flat grant recipient, she is not eligible for this service the lack of which has hindered effective medical care and compounded the anxiety in an already stressful situation.

Example A2—Telephone.—Mary was born with a spinal deformity and is paralyzed below the waist. She is a hydrocephalic, and a shunt has been inserted. Following her discharge from a children's hospital, her mother needed to keep in touch with the doctor by telephone because of possible problems with the shunt, and for emotional support which was crucial at this time. As a flat grant recipient, however, the mother was not eligible for a telephone.

Example A3—Therapeutic diets.—A 45 year-old diabetic mother, who has raised 5 sons alone for the past 10 years, suffered a significant deduction in her ADC check when the I.C.S.P. was implemented. The 2 oldest sons have college scholarships and are doing well academically. The patient obtained her high school diploma at night school and is now enrolled in junior college. She hopes eventually to get off ADC but the present situation is stressful and discouraging. She is not eligible for carfare to school or help with the books she needs to study. She is no longer eligible for the diabetic diet allowance of $13.99 per month. The deletion of the therapeutic diet allowance represents a serious problem for many ADC families who may have one or more members in need of a special diet. These might include a diet for gastric ulcer patients, high-protein high-calorie diets for nutritional and other anemias, and special diets for patients suffering from diabetic or renal problems. Only 15 of more than 100 special allowances previously available to ADC recipients remain. (See I.C.S.P. appendix)

B. ADC families also suffer the consequences of a system in which administrative policy is not filtered down to a grassroots level. Recipients are often given information which is inaccurate or misleading. They are not informed of services that are available, and there appears to be little accountability for the quality of vendor services provided. This applies particularly to the provision of cab services and to other services available through vendor payment.

Example B1—Cab Service.—An 8-year-old child with multiple handicaps was followed in the outpatient department of a children's hospital and needed cab transportation. The mother had to stand outside her apartment building, holding the child who is hydrocephalic, paraplegic, and wears a leg brace, waiting sometimes in vain for the public aid cab to take her to the hospital. Service was so unreliable and the experience so devastating that the mother eventually placed her child in a residential setting.

Example B2.—An adolescent suffering from cancer of the lymph glands is undergoing a course of chemotherapy at a Chicago hospital. She receives weekly injections and is making progress. She fails to keep many appointments however, because the livery cab service either fails to pick her up or comes too late. When she misses an appointment, her tumor flares. Her present livery service is reported to be an improvement over the cab service previously used. One week, she was 3 hours late for her appointment, the driver having made several stops at other hospitals en route. It was late when she reached home. The particular district office reports having only 2 cab services available to handle 200 or more cab requests per day.

This is a recurrent and extremely serious problem. Cab service is requested only when a patient is sick and unable to use public transportation. Patients suffering from cancer who receive daily radiation treatments, patients on renal dialysis, and aged or infirm recipients, are dependent on a system which compounds their problems by hindering the provision of adequate medical care. Many, in their anxiety or because they are too sick to wait or too disabled to travel by the type of service provided, use money needed for rent or food, to come by cab. Others without the money, or perhaps lacking the stamina required to get service, fail to keep vital appointments.

Example B3—Infant Formulas.—A baby born to a young downstate mother was referred to a Chicago children's hospital because of serious feeding problems. After a long hospitalization, it was found that the baby could tolerate an infant formula which costs $4.00 per can—about $64.00 per month. The downstate public aid office was unable to help this mother and baby, who had to make regular journeys to the hospital by bus for free supplies of infant formula.

Arrangements have been made during the past year for the provision of special formulas through vendor service. This is effected through the completion of form 179 by the physician and subsequent approval by the district office worker. The following problems are frequently encountered, however: (1) Not all workers appear to know or impart this information. (2) Due to delays in reimbursement through I.D.P.A. not all pharmacies are willing to accept the Public Aid form.

Example B4—Nursing homes.—A diabetic patient who had suffered a stroke was transferred following hospitalization to a nursing home in the south side community where rehabilitation services were available. The quality of care received was so poor that following further hospitalization the family requested placement in a nursing home a considerable distance from the patient's home because this facility was felt to offer superior service. The patient improved sufficiently in this nursing home to return to her own home in less than 2 months. This patient is not a flat grant recipient, but the example is used because it typifies the problems nursing home care presents, especially on the near south side. The problem of patients failing to receive care prescribed—such as the regular administration of medications or adequate rehabilitation—is a source of concern to families and hospital personnel.

C. The program lacks an adequate emergency assistance provision. Many social workers feel that the decision to grant emergency assistance to recipient families is often subjective. In recent months, there have been many instances where I.D.P.A. local offices have been slow in responding to emergency situations which by definition required prompt attention. On many occasions, assistance has been granted only after I.D.P.A. in Springfield has been involved at the initiative of a medical social worker.

Example C.—A 17 year-old patient suffering from Hodgkin's disease has been hospitalized repeatedly and is currently undergoing a further course of chemotherapy. On the day of discharge following a recent hospitalization, her mother was robbed; her pocketbook containing money and food stamps was taken. The police were notified and her caseworker contacted for emergency help since there were 7 other dependent children in the home, including a 6-month-old baby. No action was taken by the local office, but a call from the hospital social worker to the special hardship worker in Springfield secured the immediate issuance of a food dispersing order.

D. A further problem encountered by recipients and social workers is the long delay in replacement of ADC checks or food stamps that have been lost or stolen. Checks that have been mailed in error to an old address, have never arrived at the recipients home address, or problems that are the result of computer error.

Example D.—A 25 year-old mother of three had her check stolen in early May 1974. She notified the police and her caseworker, and moved to a new address on 5/14/74. She did not receive another check until August. During this period, she gave birth to a premature infant and was hospitalized for 1½ weeks following a cesarean section. She had to borrow money to get to the hospital while in labor. Upon her discharge from the hospital, the visiting nurse and social worker requested that homemaker services be provided because of the mother's poor health and the vulnerability of the premature infant. Because of the intra-agency confusion, this service was not provided. The telephone was disconnected because the patient had no funds to pay her bills, thus cutting off essential contact between the sick mother of a premature child and her physician. She was threatened with eviction for being 2 months in arrears with rent. Numerous calls were made to the local public aid office regarding the need for immediate financial help, but the social worker was told that nothing could be done, "the responsibility is in Springfield".

E. The new Intake System put into operation this summer with the primary objective of identifying "welfare cheaters", has had the effect of delaying the provision of financial and medical care, which is urgently needed in many cases.

Example E1.—A 31 year-old mother with a dependent child suffers from a thyroid problem which requires constant medication and follow-up. When she lost her steady job she was referred to her local Public Aid office for medical and financial assistance. The need was urgent because the rent was due. She was seen by the Intake worker on 8/26/74 and scheduled for a home visit to verify her need for help. During this time she had to obtain a copy of marriage license, a birth certificate, and a letter of termination from her employer. She was feeling quite sick at this time, and found this requirement very stressful. It was 2 weeks before a home visit was made. She received a letter 9/28/74 to say her case was approved and that she would soon receive emergency assistance.

Despite many calls to her district office the patient was still without a medical card, food stamps, or check on 10/9/74 at which time she received an eviction notice and had her telephone cut off.

Two calls to Springfield resulted in emergency checks. She finally received her medical card and food stamps 2 months after her application for emergency assistance. In this situation, the patient received treatment in a hospital where arrangements could be made for care to be provided as "P.A. Pending". Many hospitals do not have this arrangement however, nor would provisional care be available to patients being treated by local physicians. There are many instances, therefore in which patients urgently in need of treatment are unable to receive the care they need until elaborate investigations have been completed.

Example E2.—A 37 year-old mother of 5 dependent children was found during hospitalization June 1974 to have sarcoidosis, which left her weak and short of breath. Prior to hospitalization, she had worked as a machine operator with income supplemented by Public Aid. Because the patient would no longer be able to work and required homemaker help, an application was made for full assistance in early July with cover letter and forms 184c and 126h to her local district office. Two weeks later, in a follow up phone call, the hospital social worker learned the forms could not be found. Duplicates were requested, on receipt of which it was indicated that the public aid worker would make a home visit. By mid-August, no home visit had been made, and again the worker was told that no action could be taken until the patient was visited in her home.

In September, the patient again received her original allowance; the home visit was still pending. This mother finally received her full check on 10/25/74, over 4 months from the time of application and following several calls to the C.A.O. and local office district manager.

Example E3.—A grandmother notified her Public Aid worker on 6/1/74 that, because of her daughter's drug addiction and negligence of 2 young children, she was taking her grandchildren to live with her. The children were already receiving ADC in their mother's name. The grandmother had moved in March 1974, but her case had not been transferred to the appropriate Public Aid office.

Eleven weeks later, the new Public Aid office had located the grandmother's case, but maintained that it had no record of her request to add the grandchildren to the budget. Medical cards for the children and a dispersing order were promised, but she was informed on 8/23/74 that nothing could be done without birth certificates for the children. This entailed further delay, carfare to the Civic Center and a charge of $2.00 for each birth certificate. The grandmother returned to the worker with certificates on 8/28/74. The worker was out sick but the grandmother was told that she could take card number 99 and wait for the supervisor. She finally saw her own worker on 8/30/74, 3 months after the initial application.

During this period, the children had required, but could not receive medical care because their names were not on their grandmother's medical card.

Example E4.—A diabetic mother of 4 dependent children is markedly handicapped with severe foot ulcers and osteomyelitis of the ankle which has necessitated 2 hospitalizations and the use of crutches for the past year. In June 1974, a state investigator made a home visit. Verification that the patient's three daughters were in school was required. College registration papers, receipts for books, etc. were shown, but the daughters were cut off the ADC check for August, possibly because they were not present at the time of the home visit. The mother received an allowance for two to support herself, three teenagers and a younger child. House payments fell into arrears, with subsequent fear of foreclosure. The telephone was disconnected, and utility payments fell further behind; gas and electricity were cut off temporarily. A call to Springfield resulted in the issuance of "emergency" payments. The special hardship consultant in Springfield suggested that apart from a 2 to 3 month backup of cases in the local office financial department, a system in which a state investigator, a service worker, an income maintenance worker, a medical worker and a financial worker are all working independently on the same case contributes to confusion in delivery of services.

The emergency check for September did not arrive before school commenced, and clothing and special supplies could not be purchased for one daughter who was sent home from school temporarily because she did not have gym shoes. (An older son had already dropped out of trade school for want of carfare and essential supplies.)

In October, the three daughters were again omitted from the patient's check and again she was without food stamps. The Special Hardship consultant indicated that the computer had rejected the correct information and that further emergency payments would have to be requested. A good dispersing order for $56.00 was issued. Following further phone calls to Springfield, the patient finally received her full check in November. The realty company involved does not accept partial payments, but the patient was then in a position to make the full 3 months house payments, and sent the total amount of $757.00 by money order 11/9/74. The realty company called on 11/19/74, however, to say that the money order had not arrived, that they had "no time to check with post office" and were foreclosing. The situation was referred to a legal aid attorney and the problem is now resolved.

Recommendations.—1. A program which recognizes special needs of recipient families with health problems by providing special allowances, or a broader program of items and services obtainable by vendor payment, should be developed by I.D.P.A. and made known to recipients and to those concerned with their care. It should also be ensured that medical equipment such as walkers, wheelchairs, orthopedic appliances, and other items essential for a patient's ongoing care are provided without delay.

2. An accountability system to monitor the quality of services provided under the vendor payment program should be developed. This relates particularly to the provision of cab service and payment for nursing home care.

3. The current Emergency Assistance Program should be modified to allow for the granting of emergency assistance by local offices according to departmental policy. Procedures relating to the replacement of lost or stolen checks or food stamps should be clarified and efforts made to minimize the time required for replacement.

Section III.—General Assistance

In the past year, three major problems have become apparent in the General Assistance program: (a) Lengthy delays in the processing of General Assistance applications. (b) Low and inadequate grant levels, and (c) Reduction in the number of supportive services provided to G.A. recipients.

A. The process of obtaining general assistance is difficult and time consuming. At present, an applicant can expect a minimum wait of 30 days extending upward to 8 weeks after an initial screening for complete processing of his or her application. Even though G.A. applicants are often eligible for emergency assistance, they have limited access to such funds since there are lengthy delays in the application process.

Under the current G.A. administration, no provisions are made for individuals who are applying for temporary assistance because of health problems. G.A.

applicants are often individuals recently discharged from hospitals who are awaiting action on their S.S.I. applications and need assistance in the interim. They, like other G.A. applicants, must endure the 6 to 8 week delays in processing, the deplorable conditions existing at the central G.A. office at 25 S. Damen, as well as the added problems of monthly trips to the office to reapply for assistance.

Example A1.—A 45 year-old man was mugged and robbed. His wallet and identification card were stolen and his glasses, without which he cannot see, were broken. He was examined in a hospital emergency room and found to have contusions and fractured ribs, as well as other medical problems which required follow-up. He was temporarily unable to work and had no income. Because he was between the age of 18 and 55 years, he had to go to the central G.A. office at 25 S. Damen the next day at 7:30 a.m. to get in line to apply for assistance. He was given a return appointment for 3 weeks after his original inquiry, at which time the processing of his application began.

B. Many medical social workers and recipients have also become increasingly aware of the inadequacy of current G.A. grant levels. Due to the recent spiraling inflation, many patients recently released from the hospital are unable to obtain the diet necessary to ensure their recovery.

Example B.—A recently divorced woman currently a G.A. recipient was admitted from a hospital emergency room with pneumonia and in diabetic ketoacidosis. Her condition is now stablizing and she will be discharged to follow an insulin dependent diabetic regime, which should include an appropriate dietary intake. This patient would not be considered disabled under the federal disability program, and will therefore continue to be a G.A. recipient until such time as she is able to obtain employment. During this time her food allowance will be less than $1.25 per day since G.A. recipients are not entitled to diabetic diet allowances.

C. According to the I.D.P.A. General Assistance Manual, "department policy has restricted medical services allowable to necessary or essential medical care (and) preventive care is not considered essential", (#501). Certain services once available to G.A. recipients were discontinued on March 1, 1974. After that date, G.A. recipients could no longer receive much needed dental care (except in emergency situations in which tooth extraction was necessary for the relief of pain), corrective glasses needed after cataract surgery, private duty nursing, occupational and speech therapy, prosthetic devices, podiatric services, and home health care.

Example C.—A glaucoma patient with minimal vision in one eye could have improved vision with corrective glasses. I.D.P.A. in Springfield has refused approval for this G.A. patient because only "life saving" equipment or "equipment to facilitate hospital discharge" can be approved for G.A. recipients.

In the absence of precise guidelines, it is difficult to know the extent of services available to G.A. recipients. The current (unwritten) policy appears to be the acceptance of all requests for processing. Prior to 1/1/74, local G.A. workers could confer with medical consultants in Chicago. All requests now go to Springfield for review and there is no way of knowing in advance, whether a particular item or service will be approved. For many recipients regularly receiving G.A. who may be sick, but not sufficiently so to qualify for Federal Disability Benefits, or for recipients awaiting determination of disability, the confusion is not only frustrating, but constitutes a real health hazard.

Recommendations.—1. The current G.A. intake process should be modified by the addition of more staff and the elimination of long waiting periods which current applicants must endure until the applications are accepted. Arrangements should also be made for G.A. applicants with medical problems, to be seen at their local offices, without delay and without age discrimination.

2. The scope of medical services for G.A. recipients should be broadened with the additional focus being on preventive rather than on emergency medicine. Dental care, the provision of dentures, eye glasses and other essential services should be reinstated, and steps taken to increase budget allowances to provide maintenance of an adequate diet and standard of living.

3. It is also important that provision be made for G.A. recipients to receive inpatient or outpatient psychiatric care when indicated. Recipients are eligible for care provided through State mental hospitals and mental health clinics. There are circumstances, however, in which this would not be appropriate such as in the case of a patient with a serious physical problem who might be temporarily on General Assistance (pending approval of disability status) and who required psychiatric care concurrently with treatment of his physical problems.

Section IV.—Food Stamps, Medical Assistance—No Grant (*MA–NG*)

Many non-financial recipient individuals or families are eligible to receive benefits of the (a) food stamps, (b) MA–NG programs. They, like recipients have become victims of the short sighted policies and planning evident in public assistance programs.

A. The federal government recently proposed increasing the amount of money individuals and families must pay for their food stamps. Social workers recognize the effect such action would have on recipient and non-recipient participants in this program. The poor, especially those who are ill, are the first to feel the impact of inflationary prices. They are already suffering the consequences of inadequate diets since current food stamp benefits do not permit the purchase of nutritious foods.

Example A.—A diabetic mother of 3 teenage children who suffered a substantial cut when the flat grant came into operation typifies many mothers who because of the inadequacy of the flat grant and deletion of special allowances, frequently finds herself unable to purchase the food stamps she so desperately needs to feed her family. Cab fares for emergency clinic visits, school fares, school books, necessary clothing, can only be taken from the public aid check intended to cover rent and food: there is no other resource. Private agencies are unable to help in this type of situation which hits hardest the family with teenagers striving to get an education.

B. Many low-income families are eligible to participate in the MA–NG program by paying a certain amount each month to I.D.P.A. They frequently choose not to participate, however, because they cannot afford the high payments required by I.D.P.A. For a single person, any income over $150 per month is regarded as available for payment toward a medical card; fo ra couple, any income over $200 per month is regarded as excess income. Instead of offering a social service to the poor by ensuring quality medical care at low cost, this program serves as a medical insurance program which often excludes them from participation.

The MA–NG program also fails to meet the needs of many elderly or chronically ill persons by failure to regard housekeeping and homemaker services as "medical services", and available as such to sick and aged recipients.

Example B1.—A 54 year-old woman was hospitalized 4 months ago following a stroke. She subsequently developed complications which necessitated transfer to the intensive care unit. A tracheostomy was performed and she was placed on a respirator for several weeks. She carries a commercial insurance policy, but because of the severity of her condition and anticipated need for eventual transfer to an extended care facility, an application was made for MA–NG. The application was accepted, but the patient and her husband (who recently retired because of ill health) are expected to pay any income over $200 per month towards the medical card. Their rent is $125.00 per month leaving a balance of $75.00 per month for food and living expense, which in this case would include fares to visit the patient if she is placed in a nursing home since they have no car.

Because of the seriousness of this patient's condition, her husband had no alternative to an application for MA–NG. He is thankful for her survival but despondent over the financial situation in which he is now placed.

Example B2.—A 70 year-old woman who suffers from carcinoma, diabetes mellitus, and organic heart disease recently gave up her MA–NG card because she could not afford excess income payment of $113.00 per month. She and her husband, who is also sick from a heart condition and an organic brain syndrome, receive Social Security and Veterans benefits. Their rent is high but the apartment is convenient, being near concerned relatives should an emergency occur. Currently this woman is not keeping her medical appointments regularly, nor is she taking all the medications she requires.

Example B3.—A 47 year-old widow and mother of 3 dependent teenagers (one in high school, 2 in junior college) suffers from a neurological disease and is quadruplegic. She also has chronic obstructive lung disease, with congestive heart failure, and is oxygen dependent. Despite the severity of her problems, she is able to remain at home playing a significant role in the upbringing of her children. She is dependent, however, on the help of a homemaker, both in the home and in getting to the hospital for medical appointments. This patient receives Social Security and Veteran's benefits. She is therefore above the limit for S.S.I. benefits and social services. As a MA–NG recipient she is not eligible for homemaker help because this is not regarded as a medical service. No community homemaker service can offer the permanent ongoing help she needs and at the time, she is forced to break many clinic appointments, because she can no longer pay for help in the home.

This impasse regarding the provision of homemaker and housekeeping services presents increasingly serious problems for which an early resolution is essential. Many elderly and chronically sick persons can be adequately cared for in their own homes, with the provision of appropriate supportive services, such as visiting nurse supervision, homemaking services or home delivered meals. In the absence of such services, they will require more frequent hospitalizations and possibly placement against their wishes, in a nursing home.

It is also necessary that, when payment for homemaker care has been approved a system be devised to expedite payment for services rendered. Many recipients who have approval for homemaker services find that their homemakers stop coming because of the consistent delays in reimbursement.

Recommendations.—1. The amounts that families and individuals pay for food stamps should remain at present levels, but benefits should be increased in line with recent raises in the cost of living.

2. The amount that poor persons are required to pay in order to participate in the MA-NG programs should be reduced substantially to ensure that poor persons can afford and benefit from the low cost of health care.

3. It is imperative that homemaker and housekeeping services be regarded by I.D.P.A. as medical services and that they be included in the MA-NG program.

Section V.—Administrative and Intra-Agency Confusion

With the recent shift in administrative decision making to Springfield, Public Aid workers at the local level are faced with a morass of official bulletins, constantly revising policies and procedures. Morale is low and many well-motivated caseworkers are frustrated by feelings of helplessness.

In an attempt to help clients cut through the maze of confusion inherent in the present system, social workers have found it increasingly necessary to call the Central Administration Office for policy clarification, to refer patients to W.R.O. or legal aid, and to make direct contact with the special hardship consultants in Springfield.

The recent (temporary) cutback in staff at C.A.O., intensified frustration and anxiety, since it is from the casework consultants in the Special Referral Unit that guidance and help are obtained in crisis situations.

The freeze on hiring, resulting in serious staff shortages has also had profound impact on the delivery of effective services. Staff shortages are reported to account for delays of 4 to 6 weeks in getting appointments to apply for food stamps and the acute shortage of clerical staff at Hospital Application Services has resulted in a backlog of 3 to 4 months in the processing of many cases.

Example 1.—A hospitalized patient with acute leukemia applied for MA-NG in May 1974. Because of the shortage of clerical staff at Hospital Application Service, a case number was not assigned until September 1974. In the meantime, the patient was pressured for payment of hospital bills. It has been reported that in some instances accounts have been passed to collection agencies by hospitals involved in such delays.

Example 2.—A 79 year-old diabetic with severe joint disease was admitted to hospital from a south side nursing home where she was not getting adequate care. She was subsequently transferred to a nursing home on the north side where she improved sufficiently to return to her daughter's home after 5 weeks in May 1974. The patient's case was not transferred from Nursing Home Service to the local district office, however, and she had not received food stamps or medical care since May. The daughter was giving her mother excellent care but maintained she would be forced to put her back into a nursing home if the case was not acted upon promptly.

Example 3.—A young public aid recipient gave birth to a baby in July 1974. She applied for benefits for her baby but despite frequent telephone calls and the completion of 3 sets of application forms, it took a telephone call to Springfield in November to effect action at the local level. This is a frequent problem and is reportedly due to staff shortages.

Example 4.—A 45 year-old mother of 5 has been unable to work since 1968 because of a heart condition. She is raising 5 children. When the oldest turned 18, the patient requested he be taken off the budget. This was in January 1974. She continued to make this request monthly and maintains she even asked the State Investigator who determines eligibility from Springfield, to have her son's name removed from the budget since he was no longer in the home. Action was finally taken in September, when food stamps for the entire family were stopped. The Public Aid worker suggested the financial clerk might have made an error. New application forms were mailed out on 10/18/74. The patient completed the forms immediately and hand carried them to the local office on 10/21/74. She was then told that it was too late in the month for emergency stamps, but her regular stamps should come with her November check. Her November check was due mid-month. If the food stamps were again omitted, she would again be too late to apply for emergency food stamps for the month of November.

Example 5.—A 61 year-old diabetic who suffers from multiple myeloma is paraplegic with an amputated left leg. He is confined to a wheelchair and his multiple medical problems necessitate close follow-up in three outpatient clinics. His wife who suffers from multiple sclerosis is followed at another hospital.

On 9/15/73, he moved to an address in a different Public Aid district office. His caseworker failed to transfer his record, however, and in January 1974, his case was involved in the "mass transfer" which took place when a large district office was divided. His current problems stem from the fact that his Public Aid check, medical card, and food stamps, continue to be sent to the address from which he moved in September 1973. He has received no food stamps or medical card since July 1974. Appropriate forms from his local Public Aid office have been mailed out repeatedly, but are not received either by the patient or by the Department of Public Aid. His state supplement of $53.00 which should have been mailed from Springfield in early September, has also gone astray, and more forms have had to be completed for verification purposes. (His S.S.I. check comes to the correct address.) His hospital social worker has requested the emergency provision of food stamps, medical card and state supplement, but as of 11/15/74 no emergency help has been forthcoming. The patient is frustrated and exhausted by the futility of a system which appears unable to respond to his basic needs. He contrasts the present situation with that prior to 1/1/74. He maintains that in the past, if an error occurred, an emergency check would have been issued immediately, "now all you get is another bunch of papers to complete".

Section VI.—General Recommendations

1. It is our impression that many of the inadequacies in current Public Aid policy are the result of short sighted planning on the part of administrators who may have little contact with recipients or with those responsible for their physical care. We suggest therefore that a committee of recipients, medical and psychiatric social workers, and agency representatives knowledgable about the plight of sick persons should be appointed by the Governor and/or the Director of I.D.P.A., with the task of recommending changes in administrative policy to meet the current crisis. This committee should include S.S.I. and I.D.P.A. staff who are aware of problems at a local level. We recommend that this committee be consulted regarding the development of Public Aid programs in the future.

2. Because of the increase in emergencies related to (1) problems inherent in the present system, including human and computer errors, (2) the current state of the economy, with increased unemployment and high cost of living, (3) the increase in crime which in addition to acts of violence, includes a marked increase in mail box thefts, we recommend that consideration be given to the provision of a 24 hour emergency hot line, possibly through the Chicago C.A.O., to ensure an immediate response to crisis situations.

3. With the spiraling cost of living, the Department should take the initiative in providing periodic cost-of-living increases to recipients of all categories of public assistance, to ensure adequate nutrition and to serve the interests of preventive medicine.

4. I.D.P.A. should develop a systematic program of keeping health agencies and other social welfare agencies up to date regarding changes in departmental policies and procedures which have an impact on the physical and emotional well being of recipients.

5. We recognize that many of the problems identified in this report relate to staff shortages and to the subsequent low morale of I.D.P.A. staff. We therefore urge the Department to undertake a program of realistic staffing of its offices and a concerted effort to permit effective action to be taken, when indicated, at a local level.

6. Immediate action must be taken by the Illinois Department of Public Aid if current chaos is to be alleviated in the administration of its financial, social

services and medical assistance programs. Each day the confusion is allowed to continue, public assistance recipients—especially those who are ill—are victimized by programs characterized by poor delivery of service and inadequate recognition of special needs.

APPENDIX

SUPPLEMENTAL SECURITY INCOME

On January 1, 1974, the federal government implemented Supplemental Security Income—a program providing a guaranteed income for the poor who are aged, blind, or disabled. Under the SSI Program, a qualified individual can receive $146 a month and a couple, $219 a month. The implementation of SSI was mandated by the passage and signing into law of the Social Security Amendments of 1972 (Public Law 92–603). The program is the first federally administered guaranteed-income program which has been implemented for the benefit of these individuals.

Prior to the implementation of the SSI Program, many of their needs had been met by the Aid to the Aged, Aid to the Blind, and Aid to Disabled (A.A.B.D.) categorical public assistance programs, which had been administered by the various states. The eligibility requirements and the grant levels varied from state to state in spite of the fact that the federal government provided grants, to the states for operating such categorical assistance programs—providing the states adhered to certain minimal federal standards in the administration of their A.A.B.D. programs.

The eligibility of an individual or couple for the A.A.B.D. categorical programs of public assistance was determined in most states by a means test on a case-by-case basis, considering their assets and income from various sources, if they had any.

In a great many states, the means test also involved determining whether the applicant had any relatives who were legally obligated by state statute to provide assistance. If such a relative was located and it was determined that he was financially able to contribute partial or full support to the applicant, the state granted limited or no assistance, depending on the responsible relative's financial state. After eligibility had been determined, a budget of need was drafted. In calculating individualized budgets, most states considered the needs of the eligible applicant and then met a standardized percentage of the applicant's budget requirement. (This percentage varied from state to state). Very few states met 100% of the eligible applicant's budget need.

The figures used in the drafting of a budget were often not the actual amounts which the recipient paid for various items (e.g., rent, utilities, and food), since most states had set standard amounts which they felt an individual or a couple needed in order to live at a bare subsistence level. Sometimes recipients were fortunate in that they were actually paying the maximum amount or less for an item contained in a public assistance budget. More often, however, recipients were paying more for certain items than allowed for in the public assistance budget. One of the main reasons for such discrepancies was that the maximum amounts allowed for certain items were not updated regularly in order to account for increases in the cost of living.

One indication of some of the low figures used in calculating recipients' budgets (utilizing the case-by-case approach) is that 55% of those who had previously received A.A.B.D. payments under state programs received increases in their monthly grants when the SSI Program was implemented in January 1974. More specifically, SSI grants to individuals as of January 1974 were higher than those paid to individuals by 19 states, and SSI benefits to couples were higher than those paid by 17 states under their A.A.B.D. programs.

Under the new program, which is both administered and funded by the federal government from general revenue funds, payments are based on presumptive need rather than calculated on a case-by-case basis. The eligibility requirements are uniform in that they apply nationwide, as do the grant levels. The definition of eligibility employed by the federal government regarding disability is as follows:

"To qualify as a *disabled* person, the individual must meet the same requirements as for disability benefits under Social Security; i.e., the individual must be unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months (or, in the case of a child under the age of 18, if he suffers from any medically determinable physical or mental impairment of comparable severity). This definition can include persons who have been medically determined to be drug addicts and/or alcoholics."

Note.—There is no minimum age limit for either blindness or disability.

In some ways, the eligibility requirements for SSI are far more liberal than those contained in most means tests that were utilized by states in determining eligibility for their A.A.B.D. programs. For example, under the SSI Program, relatives are not required to give support. Also, in many states a lien could be placed on the home of an individual who received assistance under A.A.B.D. Under the new program, liens cannot be placed on recipient's homes; an individual or couple can own a home valued up to $25,000 and still be eligible for assistance under this federal program. Under the former state-administered programs, the maximum amounts which states allowed applicants to have in savings, or the maximum value allowed for personal items and furniture, was very minimal (e.g., Illinois allowed an applicant to have a maximum of $400 in cash assets). However, the SSI Program allows individual applicants to have $1500 in savings and married applicants to have $2500 in savings. The SSI Program also does not take into account the value of an individual's or couple's personal belongings or automobile—if the values are within reasonable limits. Most state programs did consider such items as assets and considered them in determining eligibility.

Due to the liberalization of eligibility requirements and the use of a presumptive needs approach in providing a universal grant level of payments under the SSI Program, more of the poor who are aged, blind, or disabled can qualify for much-needed assistance. Under the former state-administered A.A.B.D. program, approximately 3.2 million recipients qualified for assistance. It is now believed that, with the federalization of the program, an additional 2 million persons will qualify for assistance.

The SSI program also differs from the A.A.B.D. Programs in that it contains greater incentives for those who are aged and disabled and wish to work. Under the former programs, Aid to the Blind recipients were allowed to earn only a certain amount before their grant was affected or they became ineligible for assistance. Those receiving Aid to the Aged and Aid to the Disabled were discouraged from working since any earnings they received from employment affected their grant. Under the new program, all recipients of SSI are allowed to earn a certain amount before their grant is affected; hence SSI recipients have an incentive to seek limited employment if they are able to work.

Children who are blind or disabled also benefit from the new SSI Program. Under the old state A.A.B.D. programs, one of the eligibility criteria was the age of the applicant. If a child was poor and blind or disabled before January 1974 the child may have been eligible for payments under Aid to Families with Dependent Children (A.F.D.C.) but not for Aid to the Blind or Disabled. Now, such a child may be eligible for SSI; in many cases this will benefit the child as the SSI grant payment is often greater than the A.F.D.C. grant payments. One of the greatest advantages in the long run is the feeling, shared by many policy planners and concerned citizens that the implementation of the SSI Program has lifted the stigma of being welfare recipients from the shoulders of those poor persons who are aged, blind or disabled. In a sense, the adoption of a universal grant level and the fact that the SSI Program is administered by the Social Security Administration have legitimized public assistance to a large segment of Americans who are kept from making a decent living because of physical limitations.

ILLINOIS CONSOLIDATED STANDARD PLAN

The early years of this decade have witnessed the implementation, by several states, of drastic changes in the administration and form of their Aid to Families with Dependent Children (ADC) program of public assistance. Foremost among these changes has been the adoption of a flat grant form of ADC public assistance payments by approximately 14 states so far. Among these have been such populous states as Massachusetts, California, New Jersey, and Illinois.

On October 1, 1973, Illinois implemented the Illinois Consolidated Standard Plan (I.C.S.P.—Flat Grant Program). This ADC grant program is currently being used by Illinois in providing public assistance to families in need. Under the program, the monthly amount which an ADC recipient household receives is based on three factors: (1) The size of the recipient household; (2) geographic residence of the family (Illinois counties are divided into three categories—high, moderate, and low cost of living regions); and (3) whether or not there is an adult in the household. (The counties in each of the three regions, as well as the benefit levels for various families living in each of the regions, are listed on the following pages).

Before Illinois implemented the I.C.S.P., a "budget deficit approach" had been utilized in determining the monthly public assistance grant which a recipient family received. Under this system, each recipient family's budget was drawn up by its Public Aid caseworker. The budget consisted of a food allowance for each family member (this figure was standardized since all recipients of a given age received the same basic allowance for food), a personal essentials allowance, a housing and utilities allowance, and any special allowance which a family member of the family as a unit requested or for which they were qualified. After this total "amount of need" had been established, it was deducted from any monthly income of the family. This was referred to as meeting 100% of the recipient family's need. Unfortunately, this term was misleading since the amounts used in computing Public Aid budgets under the former system were viewed by many as being inadequate and quite unrealistic. Also, it should be pointed out that the amounts utilized in the computing of Public Aid budgets under the former system were not updated regularly. Instead, they were adjusted sporadically and hence, this system was not as responsive as it might have been to increases in the cost of living.

One of the main features which distinguish the "deficit budget approach" from the I.C.S.P. is that the former program contained over 100 special allowances for which recipient families could qualify. For example, under the former program a person could qualify for a special dietary allowance if he had a special need for it. Recipient families could also receive an allowance to purchase items needed for a newborn baby, as well as an allowance to replace worn out furniture and appliances periodically.

AFDC PROGRAM—GROUP I

The counties included in Group I are: Boone, Champaign, Cook, De Kalb, Du Page, Kane, Kankakee, Kendall, Lake, McHenry, Ogle, Whiteside, Winnebago, and Woodford.

TABLE OF MONTHLY ALLOWANCES (APPROXIMATE AMOUNTS)

	Allowance for adult(s) and child(ren)	Allowance for child(ren) only
Size of assistance unit:		
1		$69
2	$216	132
3	261	194
4	316	244
5	374	306
6	427	359
7	481	413
8	510	442
9	562	492
10	605	536
11	651	581
12	703	635
13	751	
14	799	
15	849	
16	897	
17	945	
18	993	

Note: If the size of the assistance unit exceeds the number provided above, add $46 for each additional person.

AFDC PROGRAM—GROUP II

The counties included in Group II are: Adams, Bureau, Carroll, Clinton, Coles, De Witt, Douglas, Effingham, Ford, Fulton, Grundy, Henry, Iroquois, Jackson, Jo Daviess, Knox, LaSalle, Lee, Livingston, Logan, Macon, Macoupin, Madison, McDonough, McLean, Mercer, Monroe, Morgan, Will, Moultrie, Peoria, Piatt, Putnam, Rock Island, Sangamon, St. Clair, Stephenson, Tazewell, Vermilion, Wabash, and Warren.

TABLE OF MONTHLY ALLOWANCES (APPROXIMATE AMOUNTS)

	Allowance for adult(s) and child(ren)	Allowance for child(ren) only
Size of assistance unit:		
1		$62
2	$203	119
3	245	178
4	301	238
5	356	293
6	412	349
7	463	400
8	495	433
9	544	481
10	589	526
11	635	572
12	686	623
13	734	
14	784	
15	832	
16	880	
17	928	
18	976	

Note: If the size of the assistance unit exceeds the number provided above, add $46 for each additional person.

AFDC PROGRAM—GROUP III

The counties included in Group III are: Alexander, Bond, Brown, Calhoun, Cass, Christian, Clark, Clay, Crawford, Cumberland, Edgar, Edwards, Fayette, Franklin, Gallatin, Greene, Hamilton, Hancock, Hardin, Henderson, Jasper, Jefferson, Jersey, Johnson, Lawrence, Marion, Marshall, Mason, Massac, Menard, Montgomery, Perry, Pike, Pope, Pulaski, Randolph, Richland, Saline, Schuyler, Scott, Shelby, Stark, Union, Washington, Wayne, White, and Williamson.

TABLE OF MONTHLY ALLOWANCES (APPROXIMATE AMOUNTS)

	Allowance for adult(s) and child(ren)	Allowance for child(ren) only
Size of assistance unit:		
1		$58
2	$177	112
3	217	171
4	267	225
5	324	282
6	374	332
7	426	386
8	456	414
9	502	460
10	543	501
11	590	548
12	635	595
13	683	
14	729	
15	775	
16	821	
17	867	
18	915	

Note: If the size of the assistance unit exceeds the number provided above, add $44 for each additional person.

Under the I.C.S.P., the special allowances are of four types:

1. Expenses related to participation in an approved WIN/NON-WIN Vocational Education or Training Program (I.D.P.A. is no longer providing allowances for those recipients working on a G.E.D. or college degree).
    a. Lunches.
    b. Special fees.
    c. Transportation to and from the site of such program.
    d. Child care for children of the adult recipient.
    e. Transportation to and from source of child care.
    f. Other expenses, such as special clothing, tools, necessitated by participation in one of the above types of programs.

2. Expenses related to employment (until first paycheck is received and/or as a supplement).
    - a. Lunches.
    - b. Transportation to and from job.
    - c. Special clothing.
    - d. Day care for children of the audit recipient.
    - e. Transportation.
3. Expenses related to homemaker service.
    - a. Homemaker's salary.
    - b. Social security tax or tax refund for homemaker.
    - c. Food for homemaker when meals are taken in the home.
4. Allowances being offered on a temporary "experimental basis".
    - a. Stove or refrigerator: After an investigation is made to validate need, arrangements can be made for the purchase of one of these items by vendor payment—I.D.P.A. pays supplier directly.
    - b. Junior/Senior high school allowance: All juniors and seniors in high school are eligible to receive $15.00 every three months during the school year for personal expenses.
    - c. Special orthopedic appliances: I.D.P.A. is continuing, as under the old system, to provide these special appliances under the "Flat Grant" Program. These are obtained under Medicaid.
    - d. Excess rent/house payments: I.D.P.A. is continuing to pay excess rent and house payments (235–236 Housing) to those recipients whose excess rent/house payments had been approved before 10/73.

Among the reasons which the I.D.P.A. gave for implementing the I.C.S.P. were: (1) The time required to calculate P.A. budgets by utilizing the "deficit budget" approach was too time-consuming, and (2) in some cases, families with the identical number of members of the same ages were receiving different monthly P.A. grants. For these and other reasons, the I.D.P.A. felt that there was a need for a more uniform and economical approach to the administration of their ADC program. Therefore, they considered it most appropriate to eliminate as many special allowances as possible and to simplify the budgetary process for P.A. personnel. It was the Department's view that the deficit budget approach had become outmoded, as it was a device which was arbitrary and depended upon the subjective judgment of individual P.A. workers. The Department further believed that a flat grant system would be more egalitarian.

DEVELOPMENT AND IMPLEMENTATION OF THE I.C.S.P.

In developing a flat grant for Illinois, the I.D.P.A. was guided by the experience of other states, such as California, with flat grant programs, and by recent court rulings. For example, in Rosato vs. Wyman it was ruled that a state could not extend less money for the current recipient caseload as a result of instituting a flat grant program.

When the state of Illinois initially drafted the I.C.S.P., it was found that this court ruling would be violated. Hence, the benefit levels as initially drafted had to be increased.

The method utilized in Illinois for drafting benefit levels was as follows: The I.D.P.A. took the entire amount budgeted for ADC recipient families' basic needs and all the monies budgeted for these families' special needs. Then this total was divided by the number of recipients receiving ADC funds. The I.D.P.A. then examined the distribution pattern of P.A. recipients and the cost of living within various parts of Illinois, and divided the counties within the state into three categories (high, moderate, and low cost-of-living areas). The I.D.P.A. next drafted charts showing how much funding each family of a given size residing in each of the three areas would receive. When it was discovered that almost 50% of the P.A. recipients in Illinois would receive less than the amount under the "deficit budget" approach system, the I.D.P.A. increased the grant levels in the I.C.S.P. The following page contains a breakdown of the grant amount finally arrived at for a family of 4 living in Region one.[3]

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[3] Data supplied to The Public Welfare Coalition by The Illinois Department of Public Aid.

NO. 1.—REQUEST FOR BREAKDOWN FOR EACH OF THE FIGURES INCLUDED IN THE CONSOLIDATED STANDARD AMOUNT FOR A FAMILY OF 4 IN GROUP I

Need code	Monthly average adjusted to July 1, 1969	Shelter adjustment to group I	Adjustment to current	Adjustment to proposed
Total	$255.74	$259.38	$274.50	$288.22
101—Food	93.74			
102—Clothing	26.93			
103—Household	5.80			
104—Personal essentials	13.91			
105—Restaurant allowance	.02			
106—Room and board	.02			
All shelter	101.76	105.40		
227—Laundry	2.53			
228—Phone	.10			
230—Unemployment compensation	.13			
231—Transportation—integrated	.33			
238—School (include carfare)	1.19			
239—Outsized clothing	.03			
240—Emergency clothing	1.42			
241—Layette	.09			
242—Breakage fee	.02			
243—Moving bills	.86			
244—Furniture	5.15			
245—Storage of furniture	.02			
246—Property repair	.07			
248—Special shelter allowance	.07			
250—Payment of debts	.05			
258—Deductions continued in error	.16			
259—Basic adult education	.26			
260—Vocational training and education	.26			
271—Juniors and seniors in high school	.33			
282—To and from work transportation	.05			
362—Medical expenses miscellaneous	.11			
363—Pregnancy	.06			
364—Different types of special diets	.01			
365—Different types of special diets	.03			
366—Different types of special diets	.05			
367—Different types of special diets	.01			
368—Different types of special diets	.04			
369—Different types of special diets	.01			
371—Different types of special diets	.02			
Other	.10			

Note: Not included were No. 247 life insurance and No. 249 education.

When the final I.C.S.P. grant levels drafted by I.D.P.A. were first made public, the I.D.P.A. claim that, under the new system, 76% of those receiving ADC/ADC payments would receive increases under the I.C.S.P., while 24% would receive decreases. It was pointed out to the I.D.P.A. at the time—and continues to be pointed out—that these figures are misleading. While some recipients did, in fact, receive increases in their public aid payments, they did not receive as much as they might have been eligible for under the old program, in which special allowances were granted. For example, under the old program, families were eligible for such special allowances as periodic furniture replacements, moving expenses, funds for special diets, funds to prepare for a newborn baby, school carfare, carfare for doctor's visits, and funds for a telephone if it was recommended by a doctor.

Under the old system, a family of four including a parent and three teenagers could have received the following: [4]

	Amount
A food allowance	$118.98
Allowances for clothing, household supplies, personal essentials, and laundry	71.44
A housing allowance	123.32
Total	313.74

In contrast, when I.C.S.P. was implemented such a family could receive only $288.00. It should be noted that, when the total flat grant benefits of $228.00, as in the example above, are compared with the basic benefit amounts of $242.30 for food and housing given under the old program, there appear to be substantial increases under the Illinois Consolidated Standard Plan. *However, if budgets which included special allowances under the old system were compared to The Illinois Consolidated Standard Plan, the increases would be less frequent and often nonexistent.*

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[4] Data from Public Welfare Coalition Fact Sheet, June 18, 1974.

On August 28, 1973, the Legislative Advisory Committee on Public Aid of the Illinois General Assembly voted approval of a motion that had come up in the course of its meeting, to allow the I.D.P.A. to implement the Illinois Consolidated Standard Plan on October 1, 1973. The vote on this motion followed a short presentation which officials from I.D.P.A. had given on the I.C.S.P. before the committee. Preceding the vote, the committee heard testimony from many recipients and from representatives of various professional and social agencies and other concerned citizens, asking for a postponement of the implementation of this program until (1) it could be studied by interested individuals and (2) public hearings could be held in order that the public could have an opportunity to comment on the proposed program. Those who testified before the Legislative Advisory Committee on this date were very disappointed, that the I.D.P.A. was given approval for implementation of the I.C.S.P. on October 1, 1973. It was their common opinion that there was no reason why the implementation of the program could not be postponed until an in-depth study had been carried out. They felt that it was not enough that the committee ordered the I.D.P.A. to hold public hearings through out the state in September, since no mandate was given to the I.D.P.A. to modify the I.C.S.P. after these hearings had been held.

On the same day, Governor Walker signed into law legislation which would allow the Illinois Department of Public Aid to change from utilizing a budget deficit approach to a flat grant system of administering its ADC program.

In September 1973, the I.D.P.A. did hold public hearings at various locations in the State. Unfortunately, the sites at which the hearings were held were not easily accessible to many Public Aid recipients. For example, the hearing in Chicago on September 13, 1973 at the Sheraton Chicago Hotel at 505 N. Michigan, was not held in an area generally noted for having a large number of recipients living in the vicinity. Many who did attend, had to struggle with their budgets in order to pay the necessary bus fare. Most recipients who were present were not able to eat an adequate lunch at a nearby restaurant because of the high prices. Some of the more fortunate P.A. recipients lunched on candy bars if they could afford them.

The testimony offered at the hearings in September did lead to the I.D.P.A. modifying some aspects of the I.C.S.P., but these modifications were not nearly satisfactory to those who had hoped to ensure the adequacy and success of the program. Among the modifications made by the I.D.P.A. were (1) A $15.00 quarterly allowance, to be given to those members of a recipient household who were juniors or seniors in high school; (2) the Department would provide through the use of vendor payments, stoves and refrigerators to those recipient families who were found, after a thorough investigation, to be in need of such appliances; and (3) the I.D.P.A. would continue to honor its commitment to provide excess rent and mortgage subsidies to those recipients who had obtained approval for such payments prior to the implementation of the I.C.S.P. However, when a family moved the dwelling for which the excess rent or house payment had been approved, it would no longer receive the monthly subsidy.

Individual after individual who testified at the meeting of the Legislative Advisory Committee on Public Aid on August 28, 1973 and at the hearings held by the I.D.P.A. throughout the state in September 1973, raised questions concerning the adequacy of grant levels contained in the new program as well as the lack of realistic provisions for emergency situations, and questioned the feasibility of eliminating over 90% of the special allowances which had been contained in the old program. Many of those who testified were particularly concerned about allowances pertaining to special medical needs (e.g., special dietary allowances, the provision of carfare to recipients for visits to doctors and clinics, and telephone allowances for those who require them for medical reasons.)

Department representatives responded to such questions by stating that money which had been provided for special allowances had been averaged into the I.C.S.P. benefit grant levels. They also informed those present that one of the benefits of the I.C.S.P. was that it would allow recipients more freedom, greater independence, and hence, responsibility in deciding how to spend their money. The I.D.P.A. noted that recipients would not have to depend on the judgment of their caseworker to obtain a special allowance. In short, recipients would have to budget their grants to meet special needs if they had any.

Unfortunately, spokespersons from the I.D.P.A. never addressed themselves to the inadequacies of this program. In the testimony presented at these hearings, a recurring theme was that a flat grant would not succeed unless its benefit levels were adequate and social services were offered to supplement the cash assistance program. In regard to the adequacy of the benefit amounts in the proposed program, several of those testifying, among them spokespersons for the Welfare Rights Organizations, the Public Welfare Coalition, League of Women Voters and the National Association of Social Workers pointed out that the grant for a family of 4 of $288.00 plus the amount of food stamps a family of 4 would be eligible to purchase, fell far below the budget considered by The Bureau of Labor Statistics to be needed by a family of 4 living in an urban area in order to live at an adequate subsistence level.

It should be pointed out that The Institute For Social Welfare Policy noted in its report entitled "Consolidation of Illinois Standards of Need For Public Assistance" (p. 17) : "A flat grant system, one which assumes the need of each individual to be equal, would represent no problems for the recipient if the payment level were high enough. However, the low need standards currently used by the state and those likely to be used in the near future mitigate against a system with no special needs allowances."

GENERAL ASSISTANCE

The General Assistance Program (G.A.) in Illinois is designed to meet the immediate, short-term needs of persons experiencing financial and/or medical hardships. Like the federal and state-administered categorical programs, its legal basis, found in the Illinois Public Aid Code, is to "assist in the alleviation and prevention of poverty and thereby to protect and promote the health and welfare of people of this State." However, unlike categorical assistance, G.A. is administered and dispensed, as well as funded, on a purely local or township basis. Thus, though the numbers of G.A. recipients grow daily in response to the current economic crisis, G.A. remains smaller and more independently run than the categorical programs.

Because G.A. programs are administered locally without specific state or federal regulations, eligibility requirements tend to vary from township to township. However, it can be stated generally that those people who can prove financial and/or medical indigency and are not currently covered by categorical assistance are eligible for General Assistance. Therefore, the recipient population tends to include a racially mixed group of single people or married childless couples in the age range of 18–65 years who are unable to maintain the I.D.P.A. definition of a "decent and healthful standard of living." (Other eligibility considerations include income of legally responsible relatives or their non-support, the individual's financial assets and income, Illinois State residency, registration with the Illinois State Employment Service, and specific need).

Although eligibility requirements tend to be fairly straight forward and more liberal than those for categorical assistance, the process of obtaining aid reflects the chaotic state of the I.D.P.A. which was discussed earlier in this report.

The prospective recipient feels both degraded and confused by the lengthy processing of his or her application, the depressing conditions of the main Cook County G.A. Office at 25 S. Damen Street and the bureaucratic maze in the delivery of G.A. services. For example, after initial screening an applicant may expect a minimum wait of from thirty days to two and a half months for receipt of a G.A. check. Prospective SSI applicants have to reapply monthly for extended benefits. Applicants may be sent from regional to local offices without understanding which office provides service to whom. The G.A. caseworkers who were consulted did not completely comprehend the rationale for the division of services provided by the 25 S. Damen Office and the local offices.

Once eligibility for G.A. has been established and a check issued, G.A. coverage is computed to include most of the needs for "meeting basic living expenses", however small they may be. Statistics for late 1972 include monthly food allowances for a single adult of $32.44, or $1.07 per day. The current allowance is less than $1.25 per day. Medical coverage includes in-patient and out-patient hospital care, organized clinic care, laboratory services, physician's services, drugs, family planning services, nursing home services, emergency-only dental care, and transportation to the nearest sources of medical care. According to the IDPA General Assistance Manual, because "department policy has restricted the medical services allowable to necessary or essential medical care (and) preventive care is not considered essential" (#501), certain services once extended to G.A.

recipients were discontinued on March 1, 1974; among them are podiatric and optometric services including payment for eyeglasses, private duty nursing, occupational and speech therapy, prosthetic devices, home health care, and all non-emergency dental care.

Mr. Rostenkowski. Mr. Willow?

STATEMENT OF BERNARD WILLOW

Mr. Willow. My name is Bernard Willow. I came here today as both a senior citizen and a community leader. I also came as one who is thoroughly familiar with the hopes and fears of the people of my neighborhood on Chicago's Northwest side.

As chairman of the Illinois Public Action Council and past chairman of the 14th District Citizens Advisory Board, I've had the opportunity to meet and discuss our common problems with a great number of northwest community residents and can tell you of their fears and frustrations. Fear because of crime, gang activity, and vandalism * * * frustration because of changing neighborhoods, property values being jeopardized * * * and now with unemployment in Chicago at 10.2 percent, the fear of being without health insurance and attempting to pay the fantastic cost of any serious illness.

As a regular "caller" at bingo sponsored by my parish and senior citizen coalition, I can tell you of the financial insecurity which troubles our senior citizens, ravaged by inflation, beset by skyrocketing property taxes. Chicago's elderly are understandably concerned about the future indeed, about their very survival.

And as the chairman of the Eighth Congressional District Health Security Committee, I can tell you of the growing fear of serious illness, especially among senior citizens. One lengthy illness can wipe out the financial reserves of any family, be they young or old.

We need national health insurance because the people who reside in my neighborhood and are of my generation, cannot afford to bear the extraordinarily high cost of hospital care, particularly for long durations.

We need national health insurance because of the high cost of medicine. With proper treatment serious illness can often be prevented—but senior citizens are often unaware of symptoms and cannot afford expensive visits to a physician.

We need national health insurance because for many individuals, the benefits of unemployment insurance are fast expiring. Hence they will be totally without any medical coverage.

The Lakeview Citizens Council, a community group of 2,000 paid members and 160 businesses, has passed a resolution to ask this committee to hold public hearings.

I urge this committee to consider holding community hearings on the need for national health insurance in Chicago and throughout the country. Hear what the people think, hear their problems. The people want national health insurance. But don't take my word for it. Come to Chicago to the Eighth District and hear for yourself.

National health insurance is an idea whose time has come.

Today I have a petition signed by 4,000—approximately 3,900 people, of which the majority are from the Eighth Congressional District. I would be happy to present them to you, and ask you to seriously consider them.

Mr. ROSTENKOWSKI. Thank you.

Reverend Bowyer?

STATEMENT OF REV. RICHARD BOWYER

Reverend BOWYER. Thank you, Mr. Chairman. It is a privilege to speak before this committee again.

If I may, I will identify myself as chairman of the West Virginia Committee for the Health Security Act, which is affiliated with the Health Security Action Council, and we make no apologies for that.

I would also like to request, if I might, Mr. Chairman, to say a word in behalf of Mr. Asay, the chairman of the West Virginia Council of Senior Citizens, who was scheduled to be on this panel. He called me yesterday and indicated that he would not be able to be present. He has submitted his written testimony.

I would simply like to indicate that that testimony contains, I think, substantial data, particularly with respect to the senior citizens of West Virginia in a way that my testimony does not and could not, and while I don't speak for him, I do speak very highly of him, and his work and the organization which he represents.

[The prepared statement and attachment follow:]

STATEMENT OF RICHARD BOWYER, ON BEHALF OF THE WEST VIRGINIA COMMITTEE FOR THE HEALTH SECURITY ACT

SUMMARY

The West Virginia Committee for the Health Security Act appreciates this opportunity, but feels it is tragic that Congress continues to delay passage of Health Security while millions of Americans suffer from the lack of a universal, comprehensive fully paid program of national health insurance which has both cost and quality controls.

While we do not see Health Security as entirely problem free, we see other options as very problematic and failing in all major areas for a good national insurance program. The current situation is worsening and needs a comprehensive solution with both cost and quality controls.

This Testimony looks at approaches we reject and then at the Health Security Act, HR21/S3.

The West Virginia Committee opposes any form of catastrophic illness legislation.—It would resolve very few problems, demand a disproportionate share of the country's dollars for a small part of the population, and foster the growth of specialties at a time when the need is for more of general family medicine.

The West Virginia Committee opposes H.R. 6222, "The Comprehensive Health Care Insurance Act".—It continues to leave a burden on the people who need help, making co-insurance necessary. It has no cost control and makes no serious effort at the much needed reform of the health care delivery system.

We would stress that Health Security is in no sense to be compared to the British National Health Service. Health Security does not nationalize health services any more than any other bill for this Congress. It is not "Socialized Medicare". Hospitals, etc. would continue under present ownership. It does not strip patients or physicians or hospitals of their legitimate rights. But Health Security would help all parties play their proper roles more adequately.

There is discrimination in the health care industry which is felt by the elderly, the poor and women particularly. The working people of America are also increasingly finding that they too cannot get the care they need at a cost they can pay and so are denied their right to life, liberty and the pursuit of happiness. Supplemental material especially on women, is provided only for the committee staff.

The West Virginia Committee supports the Health Security Act, H.R. 21.—At a projected cost of only 116 billion, all Americans would be covered by virtually every health care need. A resources development fund will help—in advance—to prepare more personnel resources in order to make it work for everyone.

H.R. 21 has strong cost control which will appeal to the conservative as well as the liberal. It would redirect present monies and not add new taxes. It is a good bill for the taxpayer. It reforms and assists the present "system" of delivery.

We urge its passage.

TESTIMONY

Mr. Chairman, it is a privilege to speak before this committee again in behalf of one of the most needed and therefore, most significant pieces of legislation with which this or any Congress of the United States has had the opportunity to deal.

It is a tragic fact that at this late stage in our nation's history we are still acting as if the facts aren't in. We are still behaving as if things are different than they are. We are postponing that which the judgment of history proclaims in our ears needed to be done a generation or more ago. And we are doing for the sake of a comparative few what the majority not merely wants, but obviously need.

This is not meant as an indictment of this committee. It is an indictment on all of us—People, Administration and Congress. The indictment is that we, the richest nation in the world. which for 200 years has talked of the right of all our people to "life, liberty, and the pursuit of happiness"—to this day "requires some of our citizens to impoverish themselves paying for health care, others to forego care they don't feel they can afford and still others to accept second-class, charity care once they have proven themselves poor enough."

Under such circumstances it is difficult to prepare testimony in behalf of the Health Security Act—H.R. 21. The evidence is piled high all around us. It is not a lack of information but of initiative. It is not a lack of data, but of determination. It is not a lack of wherewithal, but of will.

But, the game goes on. What follows is more information and data which merely adds to the deluge of evidence that Health Security is needed now and can be afforded now.

There are several issues which need to be addressed. These include the fact that health care is a human right, at least implied in our constitution although it is presently denied to many Americans. There is also the question of the method of payment and related to that the question of how much the patient personally would pay the doctor or hospital. Further, there is the matter of cost control, and that of the reformation of the system. And, finally, there is the issue of quality control.

My approach will be to look first at proposals which we oppose. But we do not merely criticize and call for an end to the present mess: We propose an approach which will adequately confront all of these problems.

I would not for a moment imply that Health Security is a panacea or a simple solution to a vast and complex problem. Every system has its problems. and every major change brings its own discomforts. But presently, we have overwhelming health care problems, grossly unequal services in terms of location and cost. There is very little quality control except in many pre-paid and non-profit group practice clinics. There is a manpower shortage and even worse problem of maldistribution of personnel resources. We have more specialists than are needed and far too few general practitioners or family physicians.

The inequalities no longer merely befall the elderly and poor. but the working people and the middle class. The gap between the poor and the middle class widens and burden of those who can least afford it mounts. But those who earn wages and pay taxes are more and more conscious of the fact that they too fail to receive the right to quality health care.

It is our conviction that no other proposal even approaches the major problems, let alone solving them. Health Security alone deals with them all and does it well.

CATASTROPHIC INSURANCE

First, then let me speak in opposition to any form of catastrophic illness legislation. In behalf of the people we represent in West Virginia, people from all walks of life and related to numerous organizations including Church agencies, The West Virginia Labor-Federation, The United Mine Workers of America, The UMWA Health and Welfare Funds, and individual doctors and nurses as well as the poor, the elderly and others.

The major proposal is of course, the so-called Long Ribicoff Bill in the Senate. In our judgment, this proposal is more than worthless. It is quite properly called the Catastrophic Illness Bill—to pass it would be a catastrophe. It would resolve very few problems, eat up a disproportionate share of the country's dollars for a small part of the population, and foster the growth of medical specialties at a time when we need fewer specialists and more general practitioners or family physicians.

Judged by the concerns expressed above, catastrophic insurance fails on all counts. First, it is totally opposed to the view that health care is right for all. It is a classic example of health care elitism. Its philosophy says that of course no one should have a major illness, but since we will do nothing to prevent that from happening, we will make sure those who have a major illness they cannot afford do not avoid having a financial catastrophe just the same. It is a proposal to help people—but not very much. The old way puts it clearly, "With friends like Catastrophic Illness Insurance, who needs enemies!"

Since the one in need must pay, what is the method of payment and amount one might have to pay personally. It is whatever the system calls for now. It calls for insurance premiums plus out of pocket costs which might run to $8,000. What about cost control? That is inadequate. precisely because the coverage, such as it is, pays for the high cost items. It is an open invitation to inflation, high cost services like surgery, hospitals, major equipment and specialists. Would it help to reform our present "system" of health care delivery? Not at all. It is based on the view that the present system is sound and doesn't need changed. Finally, what about quality controls? They are obviously weak—because the bill does not deal with the broader issues of our total health care system.

Catastrophic fails in all counts: Health care as a right, method and amount of payment, cost control, systems reform and quality control.

The West Virginia Committee for the Health Security Act and its supporting groups totally oppose catastrophic illness legislation. The argument which some of our own members of Congress and the Senators from West Virginia offer along with supporters of such legislation is that it is a step toward good national health insurance. If so, it is only so in a very demented way. All catastrophic insurance will do is made things worse. But there are those who only act rightly when they can no longer put it off in any way.

Let me quote Robert L. Smith, M.D. of Morgantown, West Virginia in a letter to our Honorable U.S. Senator Jennings Randolph dated November 3. Dear Senator Randolph: "You are to be congratulated that you have *not* co-sponsored the Long-Ribicoff Bill for Catastrophic Health Insurance. In the opinion of many of us this bill is the single greatest threat to the passage of comprehensive national health security legislation, the only legislation that has been proposed to bring financial relief to the people in their payment for health care and at the same time control costs, increase accessibility, and encourage prevention."

H.R. 6222, "COMPREHENSIVE HEALTH CARE INSURANCE ACT"

Second, we would address ourselves to HR6222 or the bill favored by the American Medical Association. The provisions of the proposed bill make it clear that health care is regarded as a privilege.

The method of payment requires additional fees for each doctor visit or hospital stay in addition to the insurance premium. It would cost the patient up to $2,000 for only partial coverage. There are no cost controls.

Surely at this point, we should have learned our lesson. When the chief opponents of needed humanitarian social legislation decide to join the band wagon and design the program, the real beneficiaries are those very opponents. Medicare is the model. Many of the complaints against that system are due to the tying of payments to "reasonable and customary fees." And while the cost of Medicare Supplemental payments are rising, benefits to those who pay are not. But those who receive the payments are certainly getting the benefit.

The Medical Association is not proposing any significant changes in the system. There is no provision for additional doctors such as the resources development fund of the Health Security Act. Also missing in the American Medical Association backed legislation is quality control.

And so, like Catastrophic Insurance, HR6222 fails on all counts; health care as a right, method and amount of payment, cost control, system reform and quality control.

The West Virginia Committee for the Health Security Act and its supporting groups totally oppose HR6222. The arguments that Health Security Act costs too much won't hold water because the Health Security Act costs very little more than the total $108 billion now being spent on health care by Americans. The argument that the U.S. government cannot administer the health security program has nothing to sustain it. In the first place, some of the existing mechanisms will be replaced—such as medicare. Secondly, there are many programs which the government does administer well. One cannot help wondering if the fact that so many opponents of Health Security Act now capitalize on government inefficiencies in medicare and other reimbursement programs does not make these greedy for those same inefficiencies to continue. Health Security is a threat to the reapers of profit from inefficiencies that now exist.

The argument that the British experience is falling apart and that we dare not pass the Health Security Act which is the same kind of nationalized health service is grossly misleading and/or terribly misinformed. The fact is that none of the proposals before this Congress for national health insurance would establish a national health service like that in Britain. That much, the Health Security Act and others have in common.

The history of the British system is totally different. It grew out of World War II and the devastation of the land. Further, the problems are largely due to inadequate funding. And it is the general state of Britain's economy that affects the National Health Service negatively. It is not the reverse. Our problem is one of over-spending. Estimates range from 7.8–8.3 of the GNP is spent in health care in the U.S.

Health Security is not based on the British system, nor is it a theoretical model to replace our present non-system. It covers everyone under a single program, as part of Social Security. It anchors costs to budgets rather than continuing to reimburse hospitals on a cost-plus basis and to pay physicians the fees they have negotiated only with themselves. It assures quality by insisting that specialists must have adequate post-graduate training and that major surgery must be performed only by Board-certified surgeons. It controls unnecessary surgery and unnecessary hospitalization.

It is not "Socialized Medicine." The hospitals remain under their present ownership and control. The physicians do not become civil servants, but continue to have private status. Their freedom to choose their form of practice will increase, since Health Security through a resources development fund will help to create new HMO's and other forms of comprehensive health care systems. Patients similarly will have new options.

A major reason that Health Security is opposed by the AMA is that negotiations will take place over physicians fees and, once established, physicians will not be permitted to charge patients additional amounts. The fees negotiated with the local offices of the Health Security program will represent payment in full for services.

The other main opposition to Health Security comes from the health insurance industry which will lose a lucrative market. As other industrialized nations have done, the U.S. will no longer permit massive profiting from the sick.

It is true that a society does not and cannot legislate morality. People do not become good simply by having good laws. But it is possible to keep people from being as bad as they might be otherwise. The banning of lynching has not cured many of their racial hatreds, but it has prevented them from committing the act of murder. Health Security may not make the providers less greedy, but it will protect the public from the excesses which now threatens the economic, mental and physical security of so many.

One of the great slogans of American business is "The customer is always right." For the health care "business"—the health care industry, or among most providers of such services such a thought is held in contempt. The customer not only isn't right, he or she (and it is even worse for women) has few rights.

Health Security is a remarkable proposal. It protects the rights of the consumer without seriously affecting the legitimate rights of the provider. The consumer obtains an actual right of choice of physicians and not merely the right to choose one he or she can afford without any assurance that that person is adequately qualified. The physician, by being assured of payment, gives up a policy to which he or she has no right: that of denying care to anyone who cannot pay or cannot pay enough. I believe a doctor has a right to decide what kinds of illness he or she will treat or seek and prevent—that is, what specifically he or she wishes to practice. But no one has the right to decide which patient he or she will or will not treat—least of all based on the ability or inability to pay, age or race on sex. The health care industry today is guilty of a great deal of discrimination against the poor, the elderly and women. Regarding the elderly and poor, I refer you to the testimony of Mr. Ivan Asay, President of the Counsel of Senior West Virginians who is also in this panel and to testimony submitted by Lorita Jenab, Dean, The West Virginia University School of Nursing as found on pp. 2158–2164 of Vol. 5 of the Hearing before the Committee on Ways and Means in National Health Insurance, January 7 and 14, 1974. Regarding women, I refer you to the attached paper, "What Health Security Means for Women" by Olga Madar. This was reprinted with permission by the West Virginia Committee for the Health Security Act for the United Methodist Women of the West Virginia Conference meeting this summer.

Further, far from the out cries of our few opponents, Health Security does not encroach on private ownership or operations of hospitals and the facilities. Physicians will not be employed by the government. Patients will be able to choose their physicians and health delivery systems. Doctors will be free to choose where to have their practice. Doctors may choose to be paid by all present methods, but they cannot dominate the setting of fees.

Mr. Chairman, if I may make a side comment here. It strikes me as most ironic that those so-called conservatives who cry out for fiscal responsibility are also most opposed to the one approach to national health insurance which assures fiscal control including a plan to begin reducing the cost of health services and an end to waste and excessiveness.

To continue. Health Security, while involving consumers in planning and in decision making regarding matters which primarily relate to them, does not permit in any way the interference of lay persons in the professional judgement of health care providers.

Health Security offers more real freedoms to both providers and consumers and this allows the physician, etc. to do his or her job better and assures the consumer or patient a higher quality care.

H.R. 21, "THE HEALTH SECURITY ACT"

We have appraised two other specific proposals in terms of certain guidelines or issues. We have made general comments on other national health insurance proposals. Time does not permit a look at each of the other eight or so bills before the session of Congress. But it is only fair that we judge Health Security by the tests applied to others.

Health Security is based on the belief that health care is a right of all people. The method of payment is by premium with the government as the third party. Health Security has no deductibles or co-insurance so the patient pays nothing to the doctor or hospital for full coverage. There are cost controls accomplished by anchoring spending to budgets approved in advance.

Let me refer you to the following data compiled by the Committee for National Health Insurance from Nixon-Ford Administration Estimates of Personal Health Care; Expenditures Under Alternative National Health Insurance Proposals Fiscal Year 1975 from Department of Health, Education, and Welfare sources.

With no bill at all the expenditures were estimated at $103 billion. This Ribicoff bill, costs would be $107.4 billion with 35 million not covered. That represents 4.4 billion additional dollars for only 5 million more people. Nixon-Ford proposals would cost 109.5 billion and leave 30 million not covered. That represents an increase of 6.5 billion for only 10 million more people than now are covered in some minimal way. Health Security would cost $116 billion. While that is 13 billion more dollars almost all of that cost is redirected use of the present 103 billion. But even better—it covers everyone and not for mere basic costs but for both basic and catastrophic costs! In times of cost efficiency nothing can approach Health Security. That, it appears to me is wise and careful use of my money as a taxpayer.

Even if I didn't believe in Health Security on issues of principle, i.e., the right to care, and the injustice of the present discriminatory approaches. Even if I didn't believe in Health Security because I and all other U.S. residents would get all the health care we needed. Even if I didn't believe in Health Security for these reasons—I would be a believer because I have to pay taxes and I want my tax money used wisely and well.

But finally, Health Security does reform the system and provide quality control. It protects me and other Americans—both provider and consumer from abuses and excesses. It helps channel resources, financial and human toward their best and most efficient use. It helps make more doctors and health care personnel available. It assures reduction of unnecessary surgery and the development of unneeded services and specialities. It reduces unnecessary hospitalization. It reduces the threat of malpractice suits by removing the evil of greed from health care.

Health Security is good social legislation. It is desperately needed legislation. We urge its passage. We thank you for the chance to appear and speak. And we plead with you to move with vigor and commitment to pass this bill. The only vestige of hope for millions of Americans and for the health care industry itself.

Thank you Mr. Chairman.

"What Health Security Means for Women"

(By Olga Madar, President, Coalition of Labor Union Women)

According to insurance actuaries. . . .

Women use more health care services than men.

They see physicians more often. They have more surgeries (many of them unnecessary). And, they bear children.

Health insurance underwriters consider women bad risks because of these factors, beyond the control of women. As individuals, they often cannot obtain adequate health or disability coverage. Frequently, widows and divorced women with children are unable to obtain any health insurance for themselves and their children.

Even married women find that the medical costs of bearing children may not be completely covered under their husband's health insurance policy. Problems relating to female reproductive organs are often routinely excluded from coverage. New born babies are often not covered for the first 14 days of life.

Clearly, the American woman is in need of a comprehensive non-discriminatory system of health care services, delivery, cost control and insurance.

She can no longer afford the tender mercies of insurance actuaries.

THE HEALTH PROBLEMS

A recent study showed women make 5.6 visits to doctors for every 4.3 visits made by men.

Women consume 50 percent more prescription drugs than men and are admitted to hospitals more frequently. Hysterectomy, a major female surgery involving removal of the uterus, is the fourth most common operation in the United States.

Among women aged 30 to 53, cancer is the leading cause of death in the United States. At the present rates, one in every fifteen American women will develop the disease at some time.

Breast cancer is the most common cancer in women. In 1974, 33,000 women died of it and 90,000 new cases were diagnosed. In spite of the fact that at least half are curable if detected early, there has been no significant reduction in the mortality rate in the past 35 years.

The 11,000 deaths due to cervical cancer could be dramatically reduced if every woman had a Pap test annually and had abnormal bleeding checked by a doctor. These check-ups permit diagnosis of cancers or pre-cancerous conditions at a time when it is most curable.

In spite of the promise for cure if detected in time, a recent study showed that only 53 percent of women have had Pap tests, leaving 47 percent of the adult women unprotected.

Early diagnosis is also important in diabetes, one of our most common ailments. Of the estimated four million diabetics in the United States, two out of three are women. The earlier it is detected, the easier it is to control.

Yet, 1.6 million Americans are diabetic and don't know it. Simple blood glucose tests not only pinpoint the disease but indicate a proneness to diabetes. Overlooked or neglected, it leads to serious health problems. It is the second most common cause of blindness in the United States.

Another disease easily cured when diagnosed early is gonorrhea. Recent studies indicate that women are five to ten times more susceptible if exposed to gonorrhea than men. If undetected, it can cause sterility or blindness in babies born to infected mothers.

THE HEALTH DELIVERY SYSTEM

The shortcomings of the health care system in the United States is dramatically evident in another area of particular concern to women, the infant mortality rate. Our country ranks 17th among the countries of the world in death of infants during the first year. We lost 18.5 babies for every 1000 born in 1972. If our rate was the same as Sweden's 11.1 per 1000, over 24,000 fewer babies would have died last year.

A study done by the School of Public Health at Columbia University estimated that more than 51 percent of infant deaths in some New York hospitals could have been prevented with proper pre-natal care.

In spite of the urgency of pre-natal care, more than one-third of all women delivering babies in public hospitals in the United States received no pre-natal care.

THE COSTS AND INSURANCE CRISIS

As users of health care services, the spectacular rise in the cost of medical care is of particular concern to women. *During 1974, it cost an average of $485 for health care for every member of the family.*

Health care is now 7.7 percent of the gross national product. For the last ten years health care costs have been increasing at an average rate of 11.7 percent per year. But only one fourth of personal expenditures for health is covered by private health insurance.

Lack of coverage has not prevented a rise in the cost of insurance premiums. The average cost of health insurance is now over $60 a month.

A catastrophic or chronic illness would be impossible for almost everyone. But even a short hospital stay could wreck a family budget. Two-thirds of American families would go into debt if they had to meet $2000 in medical bills out of their own pocket. With hospital rooms at $135 per day and soaring, and average maternity costs over $1000 per confinement, it is not hard to get such a bill.

WORKING WOMEN

There are 36.5 million working women in the United States. They comprise 40 percent of the total work force.

Of these women, over 6.6 million were listed by the Department of Labor as heads of families and the sole support of dependent children.

Over 61 percent were single, divorced, widowed or had husbands who earned less than $7000 per year. The salary of nearly all the working women contributes to family income and is necessary to maintain the family standard of living.

In spite of the importance of women to the economy, women are often unable to get adequate health and disability insurance. And, the insurance that she can purchase will provide less coverage than for her male counterpart.

Commercial health insurance is a business run for profit. Ideally, the perfect risk is a healthy person who has little chance of using insurance. Women, whose "actuarial experience" is higher, usually due to maternity care, are not considered the best risks. They are "losers." (Every claim paid by the company is considered a "loss.") Commercial health insurance companies call women "clunkers."

Marketing practices of these companies to guarantee profitability creates special problems for all women, regardless of income or marital status. Women, older persons and the handicapped do use more health care services than young men. So businesses that hire women have a claim experience which causes higher rates.

A large insurance company's agent's manual warns employers, that hiring females may result in higher than average claim costs saying: "some married women are willing to accept a loss of income periodically rather than face up to the hardships of working full time and caring for their homes and families." If women represent more than 11 percent in benefits, the company increases the group health insurance premiums.

Aetna Life and Casualty, the nation's largest commercial health insurance company, admitted before the Senate Antitrust and Monopoly Subcommittee that when 60 percent of the employees were women, they would write group health policies only if a life insurance policy was also written for each employee. The life policy assures profits.

Another marketing practice is the system of exclusions or "riders." These are technical terms used to describe the practice of refusing payment for any disease or disability which has affected the insured person prior to the time an insurance contract is signed. For example, a person with diabetes may be allowed to purchase coverage, but no payments will be made for any medical treatment or hospitalization related to diabetes. This makes health insurance of limited value to persons with diagnosed chronic conditions.

Women are placed in double jeopardy by many companies. Not only are they subject to the usual riders, *many medical treatments exclusive to women, such as disorders of the female reproductive system, are excluded.* Most companies also sharply restrict their coverage of pregnancies and make maternity benefits optional, requiring higher premiums with a waiting period of ten months.

The Pennsylvania Insurance Commissioner's Advisory Task Force Report on Women's Insurance Problems found maternity benefit discrimination in both non-profit and commercial plans. For example, Pennsylvania Blue Shield Plan B paid a flat $90 for a normal delivery, in 1974. That is 37 percent of the average $243 doctor's charge (excluding hospital costs) in Philadelphia. By comparison, the fee for an appendectomy in the same plan was $150 or 70 percent of the bill.

The inadequacy of maternity services is accompanied by inadequate coverage of family planning, contraception, fertility-related services and abortion.

These services are considered critical to the delivery of healthy children and the prevention of unwanted pregnancies.

When it comes to disability insurance, women find it almost impossible to get equal treatment with men.

A 30 year old "superior risk" male can buy accident and sickness insurance from New York Life, paying benefits from the 31st day of disability to age 65. For this coverage in 1972, he paid $49.94 annually per 100 of monthly benefits. A women of the same age and risk category paid $58.99 per $100 of coverage for benefits lasting only five years.

The Equitable Life Assurance Society offered plans providing monthly benefits of up to $1500 to men classified as AAA (least hazardous occupations). The best policy Equitable offered to women in the same risk category, with the same income, paid maximum monthly benefits of $700. Women rated less than AA risks could not buy insurance from Equitable at all.

However, a Public Health survey in 1971 indicates that men and women lose almost the same amount of time from work due to disabilities, including childbirth and complications of pregnancies. Men lost an average of 5.1 days and women lost 5.2 days per year per 1000 employees. Another study by 13 insurance companies support this finding. In that survey, males lost 5.09 days and women 5.27 days per 1000 employees per year.

Insurers are also suspicious of women who work for relatives. A woman who works for her husband probably cannot buy disability insurance. But if her husband works for her, he probably can.

Divorced women are also labeled as another insurance "clunker" and may be refused a family health insurance policy with the same benefits under her husband's policy, even if she has legal custody of the children.

Women are victimized by a health care system that prescribes extreme measures of treatment—usually surgery—rather than preventive care. It is estimated that two million operations are performed unnecessarily each year. Of these, hysterectomies are among the leaders. Several studies indicate that at least one-third are unnecessary.

A pre-surgical screening carried out by Cornell Medical College, indicated that from one-fourth to one-third of the recommended hysterectomies on the wives of union members could not be justified and another 10 percent were questionable. In the same study, specialists could not back up the personal physicians' recommendations for up to 43 percent of the dilatation and curettage procedures and for up to 21 percent of the breast operations. It is estimated that the pre-screening process saved the union health plans more than 500,000 in two years and the members untold anguish.

Unnecessary surgery is being performed at a time when the medical profession has the responsibility to monitor itself. But the monitoring isn't working very well. Dr. Thomas Chalmers, Dean of Mt. Sinai School of Medicine, told the American College of Physicians in 1974 that doctors used the drug silbesterol to prevent miscarriages for 20 years after studies showed it to be useless. Usage ceased only after the FDA banned it for causing cancer in the daughters of women who used the drug during pregnancy.

The quality of medical care is closely related to what happens in medical school. Not enough doctors are trained and interested in providing general care in relation to the number of surgeons and specialists. Emphasis is placed on curing rather than prevention.

As users of our health care system, women have a great stake in reforming it. In its present state, it does not work very well for the consumers. Its inefficiencies waste money and manpower and drive up the costs. Its lack of availability leaves many people with little or no care at all.

THE SOLUTION: HEALTH SECURITY

There are many proposals for national health insurance that attempt to patch up the present system. But only the Health Security Program creates reforms in the system. It establishes the principle of health care as a right. Individuals regardless of their ability to pay, their age or their sex, are entitled to full and equal benefits.

It also provides for meeting health personnel needs and makes care available to all with cost and quality controls, efficiency of delivery and consumer participation in the program policy and administration.

Health Security would pay for all hospital and physicians services, as well as for eyeglasses, hearing aides, dental services for children, mental health treatment, preventive and rehabilitative care. Some disability would be included. There would be no co-insurance, no deductibles and you'd never see a bill.

Health Security would be paid for by a payroll tax of one percent on salaries up to $21,150 per year. It would replace the one percent deduction now scheduled to finance Medicare. In other words, it would rechannel existing health care funds. The program would be administered by a Health Security Board.

Employers would be asked to contribute three and a half percent of payroll, which is less than many are now paying in private health insurance premiums. Self-employed persons would pay two and a half percent of income up to $21,150 a year. The Federal government would match the collected funds.

Health Security would replace Medicare, Medicaid and many other health programs now paid for by the Federal government.

Cost and quality controls are built into the proposal. The program would set limits on fees and require approved hospital budgeting. Other institutions would also require budget approval for payment. It would encourage the use of out-patient care rather than hospitalization for tests and other treatment. Group practice and Health Maintenance Organizations would be encouraged through incentives.

In a Health Maintenance Organization or group practice, it is estimated that consumers spend one-third to one-half less time in hospitals and undergo 40 percent less surgery. Because the services are prepaid, consumers take advantage of check-ups and screening services. Doctors, who are prepaid, have incentives to keep people healthy. Group practice provides effective peer review and has a significant effect on the quality of care delivered.

A study in 1968 comparing the number of female surgeries under Blue Cross with those under a prepaid group practice plan indicates that 9.2 hysterectomies per every 100,000 patients were performed under Blue Cross compared to 4.8 performed under group practice. Other surgeries were also reduced.

In a group practice situation, doctors can see more patients per day and therefore make more health care available. Health Security also plans to provide money for recruitment and training of more professionals and medical technicians.

The program would also give consumers a voice in deciding how the health system will work .

Grants would be given to local non-profit agencies to develop and provide social care services to benefit the aged and the chronically ill. Free standing alcohol, drug abuse, family planning and rehabilitation centers would be recognized as providers of health care services. Emphasis would be placed on preventive services and screening procedures, vaccines, pre-natal care, check-ups.

Nursing home care would be fully covered if the facility is hospital owned and operated and the care is covered by the hospital's budget. Active treatment for psychiatric care would be encouraged, as would prescribed drugs needed for costly illnesses.

The Health Security Program would assure quality health care for all Americans.

Mr. ROSTENKOWSKI. Mrs. Fearon?

STATEMENT OF ZITA FEARON

Ms. FEARON. My name is Zita Fearon, and I am from New York. We represent the board of 30 hospitals participating in the health program.

I think the speakers for health security have most eloquently prepared the case showing the need for sweeping changes in our health care delivery system.

From my experience, I am going to concentrate on a number of problems.

First, before I really get into my remarks, I just can't help making a comment about the remarks that have been passed that a new system would be the end to the free enterprise system in the country. It seems to me if one applied those same standards to other services, that we consider ours by right, that it becomes obviously silly. If I had to negotiate with the fire department whenever I had a fire——

Mr. ROSTENKOWSKI. You will have an opportunity to make your remarks after your statement.

Ms. FEARON. I have a short statement, as a matter of fact. If we had to do that, we would be in the same bad shape with those services, as we are with health care services.

In New York City, we have found that our problems are mostly financial problems, and you can imagine.

In ambulatory care, what we are faced with is the fact that 1 million people in the ambulatory care program who are medically indigent who have no coverage whatsoever, are going to be turned away because there is no money, and they are going to be sent to the municipal hospitals, at the same time, when the outpatient departments in these hospitals are going to be closed to them. There will be at least 3 or 4 million visits that will no longer occur, and the results of that, I think, are of a catastrophic nature.

My remarks are going to deal with quality of care throughout, but the statement of the problem relates first of all to costs.

COSTS

The United States spends more per capital on health care than any other country in the world, with less to show for it in the level of health of the people of this Nation. Comparison of health in disease shows many nations ahead of the United States. We range 13th in infant mortality, 15th in maternity mortality, and 18th in life expectancy. We spent $104 billion on health care in the fiscal year 1974 in the United States, a 10-percent increase on fiscal year 1973, during a period of so-called price controls. The Nation's total health bill has jumped over 100 percent in the last 8 years.

Some of our worst problems have come about as a result of reimbursement mechanisms, and I would like to say that whatever system we have, I would speak to the issue of having a national health care system as opposed to an insurance system which reimburses, because that is the source of most of our problems.

REIMBURSEMENT MECHANISMS

Reimbursement is a lesson in problem exacerbation rather than problem solution, the problem being discussed being the cost of care.

From 1950 until 1965, per capita expenditures of community hospitals grew fairly steadily at a rate of about 8 percent annually, while the rate for all services in the U.S. economy for the same period was about 5 percent annually. This was mainly caused by sharp increases in the number of personnel per patient, now needed to staff and service the vastly more elaborate equipment now found in hospitals, and by wage increases which exceeded those in the general economy, since this was a period when hospital employees, once among the worst paid workers in this country, began to catch up with the majority of other workers. After 1965, hospital expenditures began to explode. (Hospital expenditures account for 40 percent of the health expenditures in the United States.) Between 1965 and 1971, per capita expenditures grew at 5 years. Service expenditures in the economy at this time grew at 7 percent annually. And 1966 was when medicaid and medicare were introduced, providing huge amounts of Federal money for health care in the form of health insurance. Medicare is run by Blue Cross or other insurance intermediaries in their usual way, providing only partial payment for some services and rapidly rising copayments, while medicaid is run as a welfare program, fraught with the usual ripoffs by the providers that accompanies most welfare programs, with the so-called receipient having no control over costs and quality.

It is generally assumed, and it has been said here today, that these programs have inflated the cost of care because the person insured now overuses and abuses the health delivery system because it is free to them. The problem has been that these programs have had no cost-containment procedures except that of rising the copayment in the case of medicare and cutting eligibility in the case of medicaid. Providers are reimbursed for costs, and their rate is geared to their costs. The medicaid rate varies from hospital to hospital, depending on their costs, and medicare sets its rates by what are the prevailing charges in a community. The cost of health care in these programs has not risen because of an unusual increase in the number of patients. Patient-days per capita grew at about the same rate after 1965 as before 1965. According to Prof. Herbert Klarman, a leading authority on the economics of hospitals, the volume of services reimbursed on a cost basis jumped 75 percent as a result of medicare and medicaid. What actually happened was the doctors and hospital administrators took advantage of this unprecedented opportunity to do their thing, improve the quality of care as they define it. What this meant was more equipment, more personnel, more tests, more X-rays, et cetera. Every doctor and every hospital had to have everything. The number of people receiving services did not increase, but the intensity of services did. There is no proof that any of these expenditures had any impact on the quality of care:

1. Poor people have twice as much illness as nonpoor, four times the number of eye defects; five times as much mental retardation; four times the amount of disabling heart disease; and three times as many orthopedic ailments.

2. Nonwhite Americans have almost twice the infant mortality rates as whites, and four times the maternal mortality rates. As noted above, our national health indexes also fall behind those of other nations.

3. Nearly half of the poor pregnant women receive no prenatal care.
4. And 64 percent of poor children have never seen a dentist.

Blue Cross has had a similar but slightly different negative impact on the quality and cost of services. From 1962 to 1971 the number of outpatient visits has more than doubled, while the number of inpatient admissions has grown by only 25 percent. The present financial crisis and deficits of hospitals are mostly attributed to the outpatient portion of hospital care. Blue Cross does not cover outpatient visits, and only partially covers emergency room visits. There is a tremendous amount of inappropriate admissions to hospitals for procedures which could and would be done on an outpatient basis, but they are not reimbursable at outpatient care. While consumers in the ambulatory care program in New York City are trying to improve outpatient care and make it available to all our citizens, so that people can stay out of hospitals as much as possible, the only way a hospital can remain solvent is to cut down on the outpatient visits and to fill up the beds. This financing mechanism prevents the attainment of quality health care and prevents care being given both appropriately and cheaply.

ACCESSIBILITY

Not only is health care financially inaccessible for millions of our citizens, but it is also physically inaccessible. The reason for this is that there is no planning for health care delivery. Hospitals and physicians practice where they want to and deliver the services that they want to deliver, irrespective of the needs of the people, or the resources available in their communities. Poor and rural communities have little in the way of health services.

In our Nation, tremendous emphasis is placed on the large teaching medical center in the large cities, when very few of our people need this kind of care.

Any financing mechanism which is based on insurance will only prolong our problems, and prolonging our problems may very well lead to the collapse of our system. Throughout the world, all of our friends, and all of our enemies have health care systems. We should join then and the 20th century by making health, care as a right, a reality for all of our people. If education, sanitation, and transportation were provided by an insurance mechanism, this Nation would be on the brink of disaster. We cannot afford to maintain the health care industry as a cottage industry; it must become a system, and it must be provided according to the following principles:

(1) It must be open to all, free from discrimination, and controlled by those who use it together with those who work in it.

(2) It must restructure health care delivery to insure effective quality and cost controls and eliminate fee-for-service reimbursement.

(3) It must bring about an end to economic exploitation in health care by removing profitmaking and by setting up a truly progressive financing mechanism.

A national health service should be run on a budget, and this will combine the best qualities of the HMO while eliminating the tremendous startup costs, since we already have the plant, personnel, and patients. The problems are organizational, involving a new financing, planning, and public accountability procedure. The bill which

Congressman Ronald Dellums will introduce in 1976 will provide us with the elements necessary to a national health service which will provide quality care to all the people at a cost this Nation can afford.

Thank you.

Mr. **Rostenkowski.** Thank you. We can afford this opportunity for an interchange among the witnesses who have testified. Is there any point that any witness would like to make with respect to another witness' testimony?

Mr. **Brandzel.** Some of the comments I have made have been made by some of the others. But I think it would be a smokescreen to say that the issue confronting the Nation with respect to health care is an issue between socialism and private industry.

I remember we went back into the 1930's when we first had the concept of group health insurance. The same groups fought that concept.

When we were trying to provide prepaid medical programs through unions and other resources, that concept was fought. It is not an issue of whether we are going socialistic, as against our present system. There is nothing here which compares to the Great Britain program. We are not engaged in a national health insurance program. The hospitals will continue to be privately owned. The doctors will practice medicine. What is actually being said, however, is that there will be a way of redistributing our present resources, $118 billion of it, that it is costing now. If we fail to do something, there will be additional amounts to Blue Cross and others, since medical costs are rising at rate of 15 to 20 percent a year.

So the issue is not one between those two philosophies of government.

I also don't think the bureaucracy is the issue here at all. It is interesting to note when the former Secretary of HEW said he would need about 45,000 additional employees if a program of this kind was administered, the private insurance companies were saying they would have to leave out 300,000 workers who are presently involved. I am wondering where the greater bureaucracy is, when one institution which would no longer be concerned with issues such as eligibility or deductibles or coinsurance and all the paperwork that is attendant upon that, and one institution rather than the hundreds of private health insurance companies that we presently have, and I wonder if any of us have had the experience of trying to get information out of private health insurance companies.

When you talk about redtape and bureaucracy, that is where it really exists.

Finally, I might add, too, that I find it very difficult to blame the problems that we have with health care on such items as permissiveness and immorality. Those are not true problems that we have in terms of health care, and I am not saying that we don't have good doctors in this country. We do. They are technologically well advanced. We may even have enough doctors. We have about 350,000. We are, however, concerned with the distribution of doctors, and with the accessibility of all Americans to these doctors.

The only bill that we are aware of that begins in any realistic way to deal with this problem is H.R. 21.

Mr. **Rostenkowski.** Reverend Bowyer?

Reverend BOWYER. Mr. Chairman, I would like to say a word about my frequent use of the term "greed" with reference to medical and other health providers, and clarify that by saying when I use that term it is not meant as a general personal accusation of all the doctors I know, or you know, or that sort of thing.

As a matter of fact, as a member of the clergy, I think I know as many greedy preachers as I do doctors or people in the insurance industry, and I do know a great number of people in all those fields.

But the system is now based on a principle which fosters greed. People in the earlier panel in some of their comments have been concerned about what the Health Security Act would force people to do, but we don't take adequate recognition, I think, of what we are now forced into.

The present system or combination of systems or lack of a system for one thing often forces a physician to hospitalize a patient when he knows that hospitalization isn't needed, except in order to get the patient's care paid for by insurance.

The doctor may not be primarily concerned about getting that insurance premium in his pocket. He may be concerned about keeping that patient from having to take his bill, his fee, out of the patient's pocket.

It may not be greed. It may be humanitarian concern at the point of the physicians.

But it is a greed-fostering system which then will make people look greedy when they are not, and it also forces those health care providers, both private physicians and private hospitals and clinics and so forth, who desire to be charitable to limit the amount of charity which they can do, and therefore they discriminate in order to stay viable economically.

My point is that if all were paid for by rechanneled costs, it would prevent that kind of unnecessary thing.

Ms. MAYER. Mr. Chairman, several times this morning and this afternoon a poll was referred to in terms of issues that are of priority to the American people. I would just like to bring to your attention that the Cambridge poll, which occurred last month, which asked specific questions about problems of health care, and whether or not people would be in favor of some type of national health care system, 57 percent of the respondents were in favor of a national health care system, and I would just like to bring that to your attention.

Also, Dr. Astler——

Mr. ROSTENKOWSKI. Are you talking about the observation that was made with respect to priorities?

Ms. MAYER. Yes.

Mr. ROSTENKOWSKI. There was a recent poll the day before yesterday. In that poll, I was surprised but when we talk about priorities, and people list priorities, national health insurance does not appear on many lists.

Ms. MAYER. Part of the difficulty, I think, that is connected with that is that the issue is not brought forth to the people. That is one of the things that we are trying to do in Illinois with the congressional district committees, and that is to bring the problems of health care before the people and ask for their response and their input.

Mr. ROSTENKOWSKI. Are there any other comments?

Mr. Martin?

Mr. MARTIN. Thank you, Mr. Chairman.

Mr. Bowyer, you said there would be no quality control, or at least implied there would be no quality control without H.R. 21 or some such similar bill.

Wouldn't it be more correct to say that there is quality control now, and that that quality control is the responsibility of the medical professionals, though, who are trained and experienced in the practice of medicine, and what you propose to do is change this so that the quality control will become instead the responsibility of people who are not professionally trained to practice medicine, but rather people who are qualified by their desire to help other people make decisions?

Reverend BOWYER. I would agree in part with that Mr. Martin.

Mr. MARTIN. I knew I made this long enough so that you couldn't agree with all of it.

Reverend BOWYER. I write my statement the same way.

There certainly are provisions for quality control in many of our institutions and in the PSRO legislation, et cetera.

Mr. MARTIN. All I am saying is that if a doctor decides an operation is needed or not needed, that is quality control.

Reverend BOWYER. Not necessarily. If it is decided by only one physician, who may have had his training quite a number of years ago, and may not have done an additional residency in any kind of particular specialty area, it would not be.

If it includes more than one physician making that decision in consultation, then it might be. I certainly don't want to imply that on matters of medical care, and real professional judgment, that I as a consumer have any right or any ability to determine that.

I am a member of the board of directors of a nonprofit organization which operates a group of clinics, and I don't come in their behalf; but as a member of the consumer board, working with a medical group, we do not make any decisions about medical matters. The kind of decisions that we determine the hours that the clinic is open, the services available to the consumer, the kind of services that are available, the support system, the ancillary services and so forth, and that kind of thing.

I think that sort of exchange between consumer provider increases quality control in the same way that comprehensive health planning has done over the past 6 or 8 years.

Mr. MARTIN. I would comment that your restraint on your board is proper and admirable.

Yes; Dr. Astler?

Dr. ASTLER. If I may make one comment, sir, and it is not in relation with this remark, and maybe it would be appropriate to wait until you are finished with your question.

Mr. MARTIN. I have a couple of questions, and I would be happy to have him go ahead and say what he has to say.

Mr. ROSTENKOWSKI. All right.

Dr. ASTLER. As a physician, I find it almost difficult to recognize the group of physicians I know and have dealt with from some of the testimony I have heard this morning. Perhaps this sounds like paranoia, but we have heard allegations here that to me are a little worrisome.

I think we represent a group of people who can hold our banner fairly high. I am speaking of physicians in this country. There are 366-some-odd thousands of us, of whom 346,000 are in active practice, and 80 percent in primary patient care.

We are the same people who have wiped out diphtheria, wiped out polio, make appendectomies safe, gall bladder surgery fast, we have developed heart and vascular replacements. We have developed inoculations for children, and worked in these areas. We have given time in clinics.

In my own country of Palm Beach, we have over 24 free clinics which we run and operate free of charge for the needy and the poor.

We are the same group of physicians who are on the battleline, and I think that when whoever considers that, whatever the problem, whether it be an epidemic in a migrant camp, a lady having the baby, an auto accident in the street, the common denominator comes back to that physician.

I would like to say that I am perhaps biased, but I am proud of our record, sir, and I feel that we are presenting this in a way that it is not representing avaricious, money-loving, cheating hogs, who are trying to get as much as we can out of the patient and suck blood from them.

From some of this testimony, I have come up with this feeling. Perhaps I have heard it and read it wrong. If I do, I apologize.

Mr. MARTIN. You mean you contend that the level of health care provided in this country is a consequence of physicians and not committees for health security acts around the country?

Dr. ASTLER. I wouldn't say it was all because of physicians. I would say gentlemen who study 15 to 18 years before they start making horrendous charges that have been alluded to, and for gentlemen who face a malpractice insurance premium of $18 to $20 thousand before they open the door, I wonder if these are the same folks we are talking about.

Mr. MARTIN. Thank you.

Mr. Brandzel in your remarks you were raising a question about doctors, which is a very important problem, because in rural areas and in some urban communities, there is not the access to medical care because of transportation problems and so forth for a lot of people.

There was, however, another bill that sought to deal with that, and this bill would seek to assign doctors just out of medical school to practice in specified areas to overcome that same problem. Would you support that kind of approach?

Mr. BRANDZEL. Of course, there is a bill which deals with that one facet of the overall problem that we were discussing today. What we are really concerned with, Mr. Martin, is an overall comprehensive bill which, among all the other elements would also provide a mechanism by which we could redistribute the medical facilities and the medical practitioners, so that there is not that imbalance which we currently have. That is only one of a number of issues which are presented to us in the delivery of our health care system.

Mr. MARTIN. Did you say you would not favor a measure that would assign doctors to practice in specified precincts?

Mr. Brandzel. I am saying if that is all that came out of the deliberations of the subcommittee, and I am not aware of the bill you are referring to, Mr. Martin, but if we dealt with that as an isolated item, it would be inadequate in and of itself in view of the medicare needs in this country.

Mr. Martin. You would not support such a measure?

Mr. Brandzel. It would depend on the circumstances. I would much prefer a comprehensive bill which included that redistributive aspect of it.

Mr. Martin. I am not getting anywhere on that one, perhaps because I don't have any place to go.

Mrs. Mayer, on the Cambridge poll that you refer to, we have had a lot of polls mentioned, and I am glad you have a new one for us.

With several of them, it shows that the sample involved the board of directors of the meeting the person attended. You are talking more of a more scientific random sample of the population. Can you tell us anything about the sample, for example?

Ms. Mayer. No, no more than I already told you, unless somebody else—Mr. Brandzel, do you know any more about the poll?

Reverend Bowyer. Yes. Mr. Delaney referred to that poll in his testimony on the first panel, and that information is included in that testimony, I believe.

Mr. Brandzel. I think it was included in testimony given earlier by Mr. Woodcock.

Mr. Martin. That is good. Because we need to be able to look at who the sample was. If it is a few people, say one particular ethnic background from one corner of one province, that might not be a representative sample from which to derive any meaningful national statistics. But we can track it down in the testimony and have a look at it, and see what the question was that was actually asked.

Ms. Mayer. Mr. Chairman, could I ask Dr. Astler a question?

You mentioned consumer abuse if we had a national health security system.

Could you tell me whether or not you have ever seen polls or any kind of satistics that document that?

Dr. Astler. Well, I am not really a pollster. I am a practicing physician. I would not be able to answer your query by quoting polls that I have at my fingertips, except to say I think it is a general observation in looking, for example, at HMO's, where you have services among healthy, well, providers and workers in the under-55 age group. They may work well, and when you get into general cross-sections of our population, they don't work so well, because people overutilize, and that is why many of the HMO's are going under and not as many are being formed, because of the matter of overutilization.

Whether you want to term this abuse or not, I wouldn't debate with you, because if you are in a HMO, you probably have a right to go there and utilize the services which are provided.

On the other hand, if you overutilize to the extent that the doctors cannot get to the sick people because I think you are sick, then I think it is in a sense an abuse. I don't have a poll to answer you I am sorry.

Mr. BRANDZEL. Mr. Chairman, if I may be permitted to respond, it happens that my organization is in the midst of making a HMO feasibility study for our members. It has not yet indicated that the few HMO's that we have, and the ones that have not been unsuccessful is not as a result of being inundated by a whole host of people. On the contrary, it is that not enough people are using it.

In passing the HMO law, the Government indicated it was concerned with the great problem of preventive care, which HMO's are intended to do, and what it was encouraging people to do in order to cut down on the costs of hospitalization, surgical costs, was encouraging people to engage in preventive medicine by encouraging people to go to their doctors, which I think is the kind of principle we want in this country.

Reverend BOWYER. May I comment on that, also?

As you may recall, I appeared before this subcommittee in the spring when you were discussing emergency health insurance and malpractice, and in response to a question from Congressman Crane, on my return home I supplied him and I believe all members of the subcommittee with data from a HEW-funded family health center operated by the Monongahela Valley Association in Fairmont, W. Va., and with data from a HMO somewhere here in the District.

Now, I can give a general reference to the West Virginia data. Over a 2-year period with virtually a total enrolled population of some 2,000 being technically low income, the per-patient visit was below the conservative estimate of the agency's administrators.

I don't have that data either in hand or in mind at this point, but if it would help this process, I would be happy to submit it when I return home.

[The information follows:]

WEST VIRGINIA COMMITTEE FOR THE HEALTH SECURITY ACT,
Fairmont, W. Va., March 17, 1975.

HON. PHILIP CRANE,
House Office Building,
Washington, D.C.

DEAR MR. CRANE: The information I promised regarding the reduction of hospitalization when private insurance is not involved follows.

Mr. Gerard Hummel, Administrator of the UNICARE program, a HEW funded pre-paid group practice plan under the Monongahela Valley Association of Health Centers, Inc. in Fairmont, W. Va. has given me the following data.

Unicare has 2,000 members, almost all low income and medically underserved. There are no medicare members, so the elderly are not included. This is the 18th month of operation. Unicare's average hospital days are only 430 per 1,000 population. A local hospital reports some 1,100 days per 1,000 population. National figures range depending on the source of data from 900–1200 days, per 1,000 population. Such programs as the Kaiser Plan will consistently run substantially below the national average.

May I call your attention in the March 5, 1975 Drug Research Reports to an item entitled "Medicaid Enrollees in D.C. HMO". I would urge you to obtain and study the data which "showed a 30 percent decrease in the number of hospital visits, 32 percent fewer days spent in a hospital; 15 percent fewer visits to physicians; and 18 percent less use of prescription drugs. The cost saving per patient in the HMO averaged 21 percent during fiscal years 1972, 1973 and 1974."

The data was on 1,000 medicaid recipients enrolled in the Group Health Association of D.C. before and after enrollment. Enrollees were also compared with a control group of recipients who received their care in the ordinary fee-for-service system.

Those concerned with possible over-utilization especially by low income or unemployed may find the UNICARE program encouraging. The administrators anticipated a utilization rate of 5.5 per patient. However, for calendar 1974 the rate was only 4.8!

It is this sort of growing data on which my testimony was based. As a consumer and concerned citizen I am perplexed and troubled that with such clear data the Congress still does not enact the Health Security Act.

Again thank you for your careful attention to my testimony.

Sincerely,

RICHARD BOWYER, *Chairman.*

The following data is an update on information presented to the sub-committee in a letter dated March 17 regarding the utilization of services by low income enrollees in a HEW funded Family Health Center, viz., UNICARE, operated by the Monongahela Valley Association of Health Centers, Inc. in Fairmont, W. Va.

FHC UTILIZATION, JULY 1, THROUGH SEPT. 30, 1975

	Projected utilization	Encounters July 1 through Sept. 30[1]	Actual utilization rate[2]
Nursing	5.2	3,593	4.2
Social services	.5	108	.13
Eye services	.3	51	.06
Pharmacy	4.8	3,872	4.32

[1] From U-table 4 and Pharmacy EDP Reports, Sept. 30, 1975.
[2] Based on member-month enrollment of 10,250 during this period.

This information will show that free or pre-paid services readily available are not over utilized as opponents of Health Security would lead people to believe.

Mr. ROSTENKOWSKI. Mr. Martin?

Mr. MARTIN. Yes, sir, Mr. Chairman.

Just to clear up one point, I know very many of the people in this panel represent organizations that have very similar names, committees for health security. Is this related to the Health Security Action Council here in Washington that we heard about earlier this morning?

Mr. BRANDZEL. Yes, it is. In my opening remarks, I indicated——

Mr. MARTIN. You are the State chairman?

Mr. BRANDZEL. In Illinois. Yes. We have a philosophical relationship. We exchange information. They don't provide us with funds, and we don't provide them with funds, but they are a main source of information for us, and we are happy to be associated with them.

Mr. MARTIN. I make no disparagement of them.

Is your organization associated with it?

Reverend BOWYER. I stated the same.

Mr. ROSTENKOWSKI. I want to thank the panel very much for its contribution.

Panel No. 3, Reverend Miller, Sister Farley, Dr. Peterson, Mr. Spencer, Dr. Lynch, Father Ehrens, Ms. Lasday, and Mr. Thornton.

PANEL CONSISTING OF REV. ELIZABETH MILLER, SECRETARY, OFFICE OF ISSUE DEVELOPMENT, AMERICAN BAPTIST CHURCHES, U.S.A.; SISTER MARGARET A. FARLEY, HAROLD B. CONFER IN BEHALF OF MALCOLM PETERSON, M.D., C. DAVID SPENCER, M.D., ANNETTE LYNCH, M.D., AND FATHER RICHARD EHRENS, THE INTERRELIGIOUS COALITION ON HEALTH CARE; DOROTHY O. LASDAY, MEMBER, NATIONAL BOARD AND CHAIRWOMAN, NATIONAL AFFAIRS COMMITTEE OF THE NATIONAL COUNCIL OF JEWISH WOMEN; AND C. VICTOR THORNTON, VICE CHAIRMAN OF THE BOARD OF TRUSTEES AND CHAIRMAN OF THE PLANNING COMMITTEE, SHRINERS HOSPITALS FOR CRIPPLED CHILDREN

Mr. Rostenkowski. Welcome to the committee. I know Ms. Lasday has a transportation problem, so if you want to proceed first, Ms. Lasday, then we will work from the right to left.

Ms. Lasday. I will be all right, Mr. Chairman, thank you.

Mr. Rostenkowski. Reverend Miller?

STATEMENT OF REV. ELIZABETH MILLER

Reverend Miller. Dr. James Christison, associate general secretary of the American Baptist Churches, was to have been here today but he was unable to come due to meetings of our general board, and I am taking his place. I will be giving testimony on behalf of the denomination, and the denominational position, but before I am through I want to add some specific comments that Dr. Christison wished to make for himself.

My name is Elizabeth Jane Miller, and I am secretary of issue development of the Board of National Ministries of the American Baptist Churches, U.S.A.

In our denominational structure the Board of National Ministries carries special responsibility for American Baptist policy on social issues and for the presentation of American Baptist positions to the U.S. Congress.

This week the Board of National Ministries adopted a policy on health care. I received word this morning that our general board has adopted that policy for the entire American Baptist Churches. That board is meeting today.

Our board is composed of constituency representatives serving from local election districts. This policy statement was approved pursuant to a denominational statement of concern, "Crisis in the Health Care Delivery System," adopted by delegates to the Biennial Convention of the American Baptist Churches in Atlantic City, June 29, 1975, resulting from a 2-year study of the health care issue by churches throughout our denomination. Both of these statements are attached in their entirety.

Mr. Rostenkowski. The statements will be made a part of the record.

Reverend Miller. You will see on the bottom at the end of the document when it was adopted. That is the last page.

Mr. Rostenkowski. We will enter that into the record.

Reverend Miller. Thank you.

One of the intentions of policy statements is to authorize and instruct the employed staff to make every effort to implement the board's decisions. Therefore, on behalf of the American Baptist Churches of the United States, I call your attention to the main points in the two statements mentioned above.

American Baptists are distressed over the condition of the health care delivery system in the United States. They see the system as being in a state of crisis. Evidence of the nature of the crisis are the escalating cost, the shortage of personnel, and the inequities in the distribution of health care services. American Baptists want Congress to do something about this situation, and they are impatient over the apparent inability of Congress to adopt comprehensive health care legislation.

American Baptists also want some very specific items to be covered in such legislation. The legislation must provide for a full range of health care services including dental, visual, and psychiatric. American Baptists are calling for elimination of all financial barriers for any U.S. resident to receive equitable health care. Health care legislation should provide for a redistribution of health care resources in keeping with needs and population rather than on the basis of economic determinism. Professional education and training for all medical and paraprofessional and ancillary disciplines should be made available to persons regardless of economic resources and social class, who qualify in accordance with public standards, and in numbers that meet the needs of the people of the United States.

Health services should include paraprofessional and ancillary disciplines such as those in the legal, ethical, and religious fields. Consumer control over medical health services should be established through appropriate majorities on boards, committees, and agencies. American Baptists also want health care resources redirected toward maintenance of health rather than the current stress on treatment of illness.

It is important to note that American Baptists believe that a broader definition of health is needed than is currently in popular usage. The state of healthiness is more than the absence of illness. As affirmed by the World Health Organization, "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."

Provision for this concept and its potential is not made in any of the plans under current consideration by the Congress.

Policy statements by the American Baptist Churches usually do not authorize support for any particular piece of legislation. The professional staff are expected to exercise judgment as to the support to be given to legislation that embodies the intention of policy statements.

It is our intention to support the most comprehensive, inclusive health care legislation.

To the extent that American Batpists represent a cross section of the citizens of the United States, we believe that the public wants such a system and that Congress should act immediately to adopt legislation to implement a comprehensive health care system.

I would like to add comments that Dr. James Christison had planned to make personally had he been able to appear before you today.

All of the bills currently before Congress are in the form of some sort of "insurance plan."

Although the insurance approach to providing a more equitable distribution of health care services has the best chance of adoption, there are some fundamental problems that an insurance plan will not resolve.

The first problem is that an insurance plan does not deal specifically with many of the problems within the system. Health insurance may, in fact, cover up some of the basic problems and even foster their continued ineffectiveness. None of the bills we have seen would deal effectively with the dilemma of multiple standards and regulations that are imposed upon health care facilities. Federal, State, and local regulations often contradict one another. This problem contributes enormously to the excessive cost of providing health care facilities. Often the regulations are not designed to protect the patient or resident as much as they are designed to protect self-interest groups within the community. The value of Federal assistance programs is often nullified by imposition of taxes in the local community.

Another basic problem with health care services in the United States is the issue of conflict of interest. Medical practitioners are not prohibited from having proprietary interest in health care facilities such as hospitals and nursing homes, laboratories, and specialized clinics. Proprietary hospitals owned by physicians are often built in the same community as publicly owned or voluntary hospitals, and are in direct competition with them. The public and voluntary institutions are expected to care for indigent patients, whereas the physicians direct patients with ability to pay to their own institutions.

There is no comprehensive well-designed, integrated health care delivery system in the United States and none of the health insurance plans deal with this basic problem.

On the contrary, our fragmented approach to health care facilities encourages and perpetuates an uncoordinated system and an inequitable distribution of such facilities.

For example, income tax laws provide an incentive for private funds to go into health care facilities. The Department of Housing and Urban Development has programs for the development and construction of health care facilities. Hill-Burton funds are made available for health care facilities by the Department of Health, Education, and Welfare. State governments have their own programs designed to promote the development of hospitals and nursing homes. Certificates of need are issued to hospitals and nursing homes on the basis of a range of criteria that vary from State to State. Several of the health insurance plans merely add to this dilemma by providing funds for health care facilities which would come under yet another administration.

None of the plans currently before Congress meet the above problems. Our health care system in the United States needs far greater changes than are envisioned in the proposed legislation.

I urge this committee to look seriously at the systemic changes which need to be made and begin to plan for a health care system that will adequately meet the needs of the people of the United States. Thank you.

[The statements referred to follow:]

BOARD OF NATIONAL MINISTRIES, AMERICAN BAPTIST CHURCHES

Voted: To adopt the *Policy Statement on Health Care*, November 10, 1975.

As American Baptists we affirm and support programs, legislation, research and other formulations which help develop a new comprehensive health care delivery system which provides quality services for all people.

Health is the harmonious integration of body, mind and spirit illustrated in the life and ministry of Jesus Christ. Health is experienced in holistic ways including individual and communal dimensions. It is seen in a perspective of totality and comprehensiveness which provides each person with the opportunity and the strength for self-expression and fulfillment.

Therefore, we support programs which:

1. Make health care resources, private and public, available in keeping with the total needs of people, rather than on the basis of economic, geographic or racial factors;
2. Direct health care resources toward the prevention of disease and the maintenance of health as well as toward the treatment of illness;
3. Provide equitable health care for all residents of the U.S.A. by eliminating financial barriers;
4. Provide professional education and training for medical, paraprofessional and ancillary specialties without regard to economic resources, race, gender, social class or marital status, provided that the students qualify in accordance with public standards and in numbers that meet the needs of the people of the United States;
5. Secure consumer control over medical health services through appropriate representation on boards, committees and agencies.

CRISIS IN THE HEALTH CARE DELIVERY SYSTEM

Jesus went about ministering to the total needs of the individual by teaching, preaching and healing (Matt. 4:23). In this way he was ministering to the whole person—body, mind and spirit. Problems in any of these areas will undermine the quality of life or a sense of well-being and as followers of Jesus Christ we are committed to a ministry to the whole person. As American Baptists we are concerned about the quality of health care for all people. Every human being has a right to adequate health care.

We face a crisis in our health care delivery system in this country. According to the best available statistics, we are aware that as many as 40 million people in the U.S. are regularly reprived of full access to the benefits of adequate health care. A disproportionate percentage are persons over 65 years of age who have little or no income earning capacity. In spite of the affluence of the U.S. it ranks 22nd in life expectancy among the nations and 18th in infant mortality. Today's escalating costs of health services, shortage of personnel, inequities in the distribution of health services and the need for preventive care call for further responses on our part. Economical health care of suitable quality must become available and accessible to everyone.

We therefore believe that a national health policy will make real the rights of individuals and responsibilities of society must (1) provide for universal inclusion in the program with access to basic health care regardless of means or any other conditions; (2) provide comprehensive coverage with special emphasis on preventive services and on the establishment of pre-paid group plans; (3) insure increased public accountability with effective cost and quality controls; and (4) increase public investment in the financing of health care and for more effective health care planning.

We support the right of the patient to full access to information about the nature of the illness, the methods of treatment (e.g. is it experimental?) and its risks and consequences. We support the right of all patients to have access to a patient's advocate or ombudsman, especially in all phases of childbirth (e.g. fathers), pediatrics (e.g. parent), or the terminally ill (e.g. close family members). We believe that those who deliver health care must do all in their power to preserve the dignity and be sensitive to the special needs of women as consumers of health care.

Comprehensive health care should include the whole range of personal health care services, such as dental, visual and psychiatric. We reaffirm that health refers to the quality of life as well as the functioning of a physical organism. Because of this, preventive health care must be given far greater emphasis than before, including community education from public schools through multimedia. Our national health care delivery system should include innovative education for health care personnel.

Medical review by peer groups is essential. However, health care is meaningless unless the care meets the standards of adequacy, not only in the eyes of health professionals but also in the eyes of the recipients. Such a health care plan must provide services based on human need, rather than ability to pay and be readily accessible to people of economic levels. Emphasis should be given to the importance of the multidisciplinary team approach (psychologist, social worker, clergy, nurse, physician) in ministering to the total health needs of the whole persons, each team member participating in the treatment plan according to professional expertise. It is imperative that the program be regularly updated, consistent with changing social conditions. There must be equitable consumer representation on health care boards as well as on councils at all government levels for the purpose of monitoring the program.

We recognize the relationship that often exists between physical ill health and aloneness, alienation and the pressure faced by persons. As American Baptists we have emphasized the value of the local church. There are potential resources for health and healing in the group life of these Christian communities which can assist persons to live with trust, hope and a sense of meaning and value. In addition, the church could make its facilities available for a variety of clinics, depending on the local need, provide short term in-depth training for more effective lay ministry, maintain an updated register of local social services, and participate actively in supporting adequate health legislation and recruiting for the healing vocations. The challenge to provide better health requires that we all work to improve the quality of air, water, food and to develop healthier habits in terms of exercise, nutrition, coping with stress and a positive orientation to living.

We believe that the greatest challenge to health care in this decade involves issues related to quality of life. We believe all levels of government, the resources of the church and Christian community and all health agencies must address themselves to these issues. We as American Baptists are committed to use our resources until a comprehensive health care system is developed and implemented for all persons. We will continue to minister to the total needs of individuals through teaching, preaching and healing as followers of the Christ.

Vote: Yes—719; No—70; Abstained—30.

The above Statement of Concern is an expression of the delegates present and voting and not a vote of the Biennial Meeting; a ruling by the presiding office stated that the delegates were acting as if in committee of the whole because a quorum call was short by 44 persons out of a total delegate attendance of 2602.

Mr. Rostenkowski. Thank you, Reverend.

STATEMENT OF DOROTHY LASDAY

Ms. Lasday. Mr. Chairman and members of the committee, I am Dorothy Lasday, a member of the National Board and chairwoman of the National Affairs Committee of the National Council of Jewish Women.

I appreciate the opportunity to appear before you today in support of an issue of great concern to my organization.

I also appreciate being taken out of turn since I don't live in the metropolitan area, and once I get to New York I have a limosine service that doesn't run after certain hours, or else I couldn't get home tonight.

The National Council of Jewish Women, an organization established in 1893, with a membership of over 100,000 throughout the United States, has been actively supporting a system of national health insurance for several decades. We vigorously supported the medicare program and other health measures since that time to improve the delivery of health care to the American people.

At our biennial convention in March of 1975, the delegates reaffirmed the following resolution:

> HEALTH AND WELFARE
>
> The National Council of Jewish Women believes that a healthy community, sound family life and individal welfare are interdependent. It believes, therefore, that our democratic society must give priority to programs which meet human needs and that the public and private sectors must cooperate to achieve this end.
>
> *We therefore resolve:* * * *
>
> 3. To support a comprehensive national health insurance program.
>
> 4. To support programs aimed at: (a) Improving health care delivery systems; and (b) Expanding medical training and research.

In its studies of the issue of national health insurance over the years, the National Council of Jewish Women has come to feel strongly that there are certain basic principles that must be incorporated into an effective health care program, and which cannot be compromised in the interest of creating acceptable legislation.

These are:

1. Coverage—a universal coverage. The entire population should be eligible for all the benefits according to their health needs and without financial tests or barriers, or conditions of age, sex, race or employment, or marital status.
2. Benefits—broad and comprehensive range of services, including preventive services for all, prenatal care, psychiatric care and health maintenance services.
3. Controls—stringent and realistic cost and quality controls. Redistribution of the availability of physicians and other health resources.
4. Financing—reduction of elimination of deductibles, co-insurance and medicare premiums and greater use of general revenues.
5. Administration—unified Government administration with the participation of recipients and providers of the services.

The national Council of Jewish Women believes that health care is a basic right of all Americans—not a privilege which must be earned, not a luxury available only to the rich. It is our view that there should be no qualitative difference in the health care and delivery services based on income differentials. Illness knows no economic or social bounds. Therefore, preventive care and remedial care should be available to all. The problems for continued payment of health insurance by the large numbers of unemployed today, especially those not covered by union negotiated plans of large employers, clearly indicate the need for universal coverage, including young adults as well as those in the work force.

But for a national system of health care to come into being we recognize it must be acceptable to those who make it work, the health professions. At the same time, there must be involvement of the private sector to insure that an acceptable quality of care is provided. It has been the growing awareness of the private sector—citizens, consumers, medical practitioners—that has called attention to the abuses of some nursing homes and hospitals whose services are funded primarily through medicare and medicaid, but also private insurance plans.

The urgency for establishing a national health insurance system was clearly defined for me when I was privileged to attend a meeting of legislators from 40 upstate New York counties with some of their commissioners of social services. The agenda on October 14 was directed at the financial crises facing all the countries, which by charter cannot have a deficit and find themselves with no choice but to float bonds at very high interest rates and then increase already high property taxes for 1976. The cause: huge overruns in medicaid and unexpected increases in aid for dependent children due to the recession.

In New York State, the local social services districts pay 25 percent of the cost of AFDC income maintenance programs and medicaid.

The upstate counties, like New York City, have found this an unmanageable burden. In Dutchess County, my home, with a population of 220,000 the expected social services department deficit of $5.2 million includes $3.4 million for medicaid alone. Yet we are a county which has not been hit as severely by the recession as elsewhere in New York State. National health insurance would take this burden away from the overloaded property tax.

In our community service activities, we in the National Council of Jewish Women have seen clear evidence of the high cost of not providing preventive health services, especially for children, for prenatal care, and for the elderly. Most of the teenage girls we have screened for Job Corps through WICS, Women In Community Services, have never seen a doctor. The records clearly show the cost of providing corrective medical and dental care in their first months of Job Corps. In contrast, our volunteers in early screening and detection programs, such as those from our Washington, D.C., section working with children in day care centers, have demonstrated the advantage of detecting physical problems early. Not only are the financial costs reduced by early detection, but also the cost due to misery and failure. Lack of preventive prenatal care causes the United States to continue to have a high infant and maternal death rate despite our large expenditure for health care, and also causes birth defects that could be prevented, such as mental retardation, blindness, deafness, and so forth. In our senior citizens programs we have seen the high costs when medical problems just must become acute before treatment is available by hospitalization.

It will not be easy to develop a national health insurance program which will insure universal access to medical care, freedom from financial hardship, dignity for the patient, and at the same time incentives to hold down medical costs. But it is imperative that the Congress make a start now.

The Kennedy-Corman bill is an effort in that direction.

Mr. Rostenkowski. Thank you. Sister Margaret.

STATEMENT OF SISTER MARGARET FARLEY

Sister Margaret. Mr. Chairman and members of the committee, before I begin my testimony I would like to introduce the members of our panel and to briefly indicate our constituency support as you have requested.

My name is Margaret Farley. I am associate professor of ethics at Yale University Divinity School.

Our next panelist will be Dr. Malcolm Peterson, dean of the School of Health Services, Johns Hopkins University.

He will be followed by Dr. C. David Spencer, who is the director of health services at the Kensington Georgetown Medical Center and clinical assistant professor of the Department of Community Medicine of Georgetown University Medical School.

Dr. Annette Lynch is presently the director of the school health program, Bureau of Children's Preventive and Restorative Services of the Commonwealth of Pennsylvania.

Our final panelist is Father Richard Ehrens, chairman of the board of directors of the Miles Square Health Center, which is the largest neighborhood health center in the United States.

Mr. Chairman, we would like to request at this time that all of our prepared statements and vitas be accepted for the hearing record.

We would also respectfully request that the policy statements of the supporting organizations in the coalition be appended to our testimony as they have agreed to support our testimony rather than taking up the valuable time of this committee by giving individual statements.

It is important to note in this regard that these 11 groups represent 36 national religious bodies (Catholic, Protestant and Jewish) which in turn represent over 41,629,113 Americans. We do not purport to speak for them as a body and are only presenting the above figures because your subcommittee staff requested them. Indeed, most religious people hold their own individual opinions as a sacred trust. We do hope the committee will note, however, the remarkable consistency in these groups various policy statements herein submitted.

I wish to speak to you today regarding the urgency of legislative action which will provide for all persons in this country—without regard for race sex, geographical location, or economic income—access to the health care they truly need.

"Right to health" care is a concept which has become increasingly accepted in our society. You yourselves have heard much testimony which takes it for granted. Yet it is, for our Nation, a newly recognized right—an extension of the rights' tradition which has been so important to us. We have not always seen the need to affirm rights which demand not only protection from interference in one another's lives (such as the right to freedom of speech) but positive social cooperation of a very high degree.

Not everyone in our country finds a "right to health care" persuasive for the same reasons. For some, it is morally compelling to see now in the United States' rights tradition a logical connection between fundamental rights to life, liberty, and the pursuit of happiness and fundamental needs for physical and psychological well-being.

In other words, some persons ground the right to health care in the United States' rights tradition. Others ground it in a philosophical understanding of natural rights, and still others ground it in, for example, the Judea-Christian religious position, which there are understandings of claim and justice which persons have on their neighbors.

Groups who have previously thought health care was a privilege have become persuaded that it is right through their growing awareness that (1) as a society we have become essentially capable of providing health care for all of our members, but (2) there is an obvious and increasingly unjustifiable disparity between the health care available to some persons and that which is available to others. Similarly, groups who previously thought that the health care of the economically poor could be provided for through charity or philanthropy have come to acknowledge that it is simply not possible to meet the needs of all persons in this way (thus, for example, in a statement presented on May 31, 1974, the National Protestant-Catholic Hospital Action Committee on National Health Insurance affirmed the need for national health insurance in this country.

I think, if I would summarize my testimony, that it is important for us to not only become clear where the persons in our society are grounded in a right to health care, but also try to get some clarity in the meaning of "right to health care." It seems to me it is used generally and often vaguely. It is at least helpful to sort out three meanings which have to do, with the right to equal access to health care.

Second, it is sometimes referred to to mean a right to quality health care, the health care one would have access to, that would have equitability in the quality, and, third, it seems to me sometimes as we talk about patient's rights generally, and within the general concept of rights to health care today, we mean the right that persons have to be treated and respected precisely as persons when they are receiving health care.

Now, those kinds of distinctions could be considered just fine philosophical distinctions without a great deal of relevance to specific legislative proposals such as those you are considering, but I would like to suggest their relevance for evaluating the options before you, for example, regarding methods of financing national health insurance.

A major question raised by current legislative proposals is whether or not the financing of national health insurance should include provision for costsharing on the part of the patients. You have heard arguments in favor of costsharing, that is, costsharing in the form of deductibles and so on, and arguments for that on the ground that, first of all, only in this way can overutilization of health care be controlled, or two, only in this way can health care be distributed on the basis of medical need, since we are operating in a situation of finite fiscal resources, where money saved through costsharing can be distributed to those whose illness is greatest, and, third, equal access to health care can include the notion that those who can pay for it should pay for it.

Yet it is clear that costsharing holds inevitable pitfalls if our central concern is the securing of the right to access to health care, to quality health care, and to respect as a person in the reception of health care. The plans before you which include costsharing (e.g., H.R. 1, H.R. 5990, H.R. 6222, and S. 2470) inevitably exclude equal distribution of health care to all persons. Deductibles and copayments, where they are demanded of the poor and of many persons in the middle class, continue to discourage and even render impossible needed use of medical care (thus, for example, the requirements in H.R. 6222—the Fulton bill—for 20 percent coinsurance on preventive services in effect excludes a large portion of the population from these services and discourages many others from seeking them even when their need for them is great).

Moreover, when health insurance demands costsharing of some and not of others (as is the case, for example, with the Long-Ribicoff—

S. 2470—medical assistance plan), we have every reason to expect a continuation of our present uneven pattern in the quality of health care provided for the poor and that which is accessible to the rest of the population. To argue that we can preserve the principle of cost-sharing, yet simply not impose it upon those who cannot afford to pay, is to miss the correlative point that a different level of financing for the poor and nonpoor has heretofore led inevitably to different levels of care for the poor and the nonpoor.

Finally, costsharing (and different modes of financing health care for poor and nonpoor) in its proposed forms threatens the principle that persons have a right to be treated according to their dignity as persons when they are receiving health care. Proposals such as the Long-Ribicoff bill, for example, which include huge deductibles (60 days of hospitalization and 52,000 in medical fees, along with a 'double jeopardy' provision to the effect that after 90 consecutive days of less than $500 in medical bills and no hospitalization patients lose their deductible protection in a calendar year) and/or which include indigency requirements (for the medical assistance plan within the bill), perpetuate a system of health care which can result in family insolvency, in the loss of a reasonable level of living, and the ultimate sacrifice of home and those things which are important in this society to a basic sense of human dignity.

We must, of course, be concerned (as are those who propose cost-sharing) with the need to recognize limits to our capability as a society to fund health care. This is why realistic proposals for national health insurance should include provisions for cost-control, for planning and budgeting, for modifying institutions of health care delivery so that hospital care is not unduly emphasized, and for introducing counter-balances to the present gravity toward fee-for-service systems of health care payment. There is important evidence that all of these means can help set realistic limits to the use and supply of health care—but without entailing the consequences of further inequities in the access of all persons to quality health care.[1]

At present, these means are attended to with most seriousness in H.R. 21 and H.R. 6283—the Corman/Kennedy bill and the Young bill.

There are two further considerations to be made if the implications of a right to health care are to be taken seriously by us now. First of all, we must remind ourselves that in order for a claimed right to affect the course of human affairs there must be specified agents whose duty it is to secure that right. In the past, the duty to provide health care has seemed to fall upon the medical profession and perhaps upon private insurance agencies and in a partial way upon Federal and State governments. But if we are now indeed to affirm that health care is a right for all persons in our society, it is clear that the society as a whole must assume the duty of securing that right.

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[1] See, for example, the study done of federal employees in a group plan as opposed to those under Blue Shield: hospital days for 1,000 persons were markedly lower among those in the group plan. U.S. Health Services and Mental Health Administration: The Federal Employees Health Benefits Program, Washington, D.C.: Government Printing Office, 1971. Also, there is some evidence that fee-for-service systems encourage over-utilization to an extent that capitation-salary arrangements do not. See Carl M. Stevens, "Selecting Health Care Systems," in L. Tancredi (ed.), *Ethics of Health Care* (Wash., D.C.: National Academy of Sciences, 1974), p. 258.

There is negative evidence regarding the efficacy of budgeting for controlling costs in the present spiralling of costs in a system which does not, by and large, demand careful prospective budgeting.

Part of the difficulty which medical and hospital providers have had in accepting health care as a right has been the implicit knowledge that such a right might place demands upon them that they could not meet.[2]

Duties are not real unless those who are said to have them possess the capability to render the service which the duty requires. But clearly only the society as a whole possesses that capability now in relation to health care (though, clearly, too, individuals have duties in this regard, and special groups such as the medical profession have special duties in this regard). This means concretely that Federal legislation is urgently needed—legislation that will equitably distribute the economic burden of health care (through, for example, progressive rather than regressive taxation), that will make the duty which exists in relation to health care a serious factor in the determining of domestic priorities, and that will introduce public responsibility.

Finally, also it must be said that the recognition of a right to health care—as the recognition of any right—may sometimes entail situations where more than one right exists, and where it is important to adjudicate between rights which seem at least superficially to be in conflict. Now it has been argued that medical providers as well as patients have rights, and legislation which secures a right to health care cannot abstract from this fact. This means that rights must be distinguished from mere wants. Rights specify those aspects of human life which society has recognized as being intrinsically important to human beings or which society has specified as being so important to human beings as to raise them above individually determined claims or desires. Medical personnel, for example, may then indeed claim the right not to be coerced into giving medical treatment which they deem unjustified medically or morally. But they may not thereby claim as a right total autonomy and self-determination in, for example, the setting of fees for medical service or in the deployment of resources. The bills which are before you as plans for national health insurance do not it seems challenge the fundamental rights of medical providers. They do, however, importantly and legitimately call all segments of society to a new level of social cooperation so that we can together secure a right to health care.

Thank you.

STATEMENT OF HAROLD B. CONFER, LEGISLATIVE SECRETARY FOR HUMAN RIGHTS OF THE FRIENDS COMMITTEE ON NATIONAL LEGISLATION, ON BEHALF OF DR. MALCOLM PETERSON

Mr. Confer. Mr. Chairman, I am presenting the testimony of Dr. Malcolm Peterson. He is unfortunately delayed this afternoon. He had a meeting with Governor Mandel which he had made an appointment for previous to this commitment and he hopes to be here in time for the question and answer session.

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[2] It is clear that private insurance agencies, for example, have not been able to succeed by themselves in the past in taking care of the insurance needs of more than about ⅓ of the population. Then, too, hospitals have become well aware of the fact that they cannot continue to supply care without additional government support. See Sylvia A. Law, *Blue Cross: What Went Wrong?* (New Haven: Yale University Press, 1974), p. 145. It is also a commonplace that physicians in the American Medical Association fear the imposition of unreasonable demands upon the services of doctors.

Dr. Peterson is the dean of the Johns Hopkins University School of Health Services. His background is described in the attached résumé which summarizes his training and experience in medicine and biochemistry.

Today he is pleased to testify as a member of this panel for the Interreligious Coalition on Health Care and to urge on the basis of 25 years as a student, researcher, scientist, teacher and practicing physician that the committee not report out any legislation on National Health Insurance which perpetuates the present structure of the medical care system. As unsatisfactory as he finds the current circumstances of the modes of payment for medical services, he foresees that enactment of any of the current bills which you are considering will serve only to widen further that enormous gap between what we can do and what we are doing to meet the health needs of the Nation.

Our present system is inadequate for many reasons, including, but not chiefly because of, the inability of many persons to pay for proper health care. But legislation which addresses only that element of the problem will just escalate the health care bill in the United States, as did the amendments to the social security laws in 1966 when Federal assurance of payment through the medicare and medicaid entitlement stimulated much greater expenditures. Any concomitant benefit to the health status of the American people has been so marginal that rigorous scientific inquiry has failed to show that any improvements in our overall health can be attributed to titles XVIII and XIX.

Nevertheless, that legislation has resulted in at least two other important outcomes: one, it has shown that simply providing payment is not enough; and two, the nearly uncontrolled escalation of the Nation's medical care bill has brought all sectors of the society to the level of apprehension and discontent about the health care system.

Now we may have the leverage which will force us to break those bonds which are preventing the attainment of the health care system which we have the knowledge, resources, and commitment to build.

Based in the experiences of American and foreign health care systems, as well as investigations of health care researchers to test certain strategies of systems design, he urges you to recommend to the Congress a bill for national health insurance which will mandate that payment for health services be linked to a reorganization of the health care system which adheres to the principles set forth in the Interreligious Task Force on Health Care statement of October 1972.

That is appended to our statement.

The implementation of those recommendations would be intended to assure, one, that the accountability for effective health services be to those receiving health care by placing the decisionmaking power in the hands of the consumers—Father Richard Ehrens will elaborate on this in his testimony—two, that the provision of all health services will be linked in such a fashion that comprehensive services are available to everyone, offering through planning and coordination the services which the public decides should be included; three, that the demands for health care be met through regionalized systems of appropriately distributed facilities and health workers, relying on appropriate categories of physicians and nonphysicians, specialists and generalists, organized and deployed according to a strategy which achieves maximum utilization of these health workers; and four, that the quality of health services be judged and controlled in relationship to criteria established by the consumers.

These suggestions are directly related to the issues about what must by now sound like a litany of health care: accessibility, availability, quality, control and cost. Dr. Peterson would like to emphasize with specific citations why simply providing insurance payments will add to our Nation's economic woes without doing anything significant to improve these elements of health care delivery.

Accountability and controls have been clearly tested and vindicated in a consumer-controlled health plans which have had an annual growth rate of 10 percent. The Group Health Cooperative of Puget Sound, and in the East Baltimore Medical Plan.

In both instances the checks on overenthusiastic professional commitment to more specialists and bigger technology as well as professional reluctance to provide desired health services have been productively channeled by sound judgments exercised by the consumer-controlled directorates. The overworked phrase "The doctor knows best" should be considered in the light of the admonition that "Health care is too important to leave to the doctors."

The people know what they want and have shown wisdom in their decision in whether or not to implement policies which have economic, social and political ramifications as well as intended health benefits.

The unnecessary use of medications, operations, hospital beds, and laboratory and X-ray services have been documented all too often for the Congress to sanction a national health insurance program which will support the attendant wasteful expenditure of money. The wasted dollars, not to mention human services and patients lives, in this inefficient system could be saved, perhaps to the tune of more than $25 billion annually, nearly a fourth of the health care bill, if we were not paying for the cost of billing on a fee-for-service system and profits in the insurance and drug industries, in addition to the unnecessary patient services he mentioned earlier.

The idea that the response to meeting unfulfilled demands for health care should be to provide more doctors is misguided. Only 2 weeks ago Dr. Peterson stated in testimony to the Senate Subcommittee on Health that we can provide more and better services by employment of health associates, nurse practitioners, and other nonphysicians in the primary health care teams, thus amplifying services of present physician manpower by deployments which can respond to geographic and specialty maldistribution. But we can't do that if Federal regulations and State laws disallow reimbursement of such practitioners even if archiac laws delimiting or prohibiting them to practice are struck down in the first place.

The fact that Dr. Peterson is currently licensed to treat patients with fractured bones, and will be for the remainder of his life, is ludicrous. Yet payments for services with regard to quality of the outcome of care is practically assured despite evidence or lack of it of his professional fitness to do this work as judged by periodic recertification, and by continually updated knowledge.

The House Ways and Means Committee has repeatedly sought assurance of economies. He urges you to address all elements of organization of the health care system as a means of achieving these desired savings and simultaneously reducing the dispartity between potential and actual realization of national goals for health care. He knows you and the public cannot wait for all of the data to be gathered, to decide what might be the optimum design, but just consider how much might be done if coherent organization were achieved by reducing overlap and redundancy in the health programs for special groups, for example, veterans, laborers, native Americans, the poor, children; coordinating public health programs, such as environmental protection, food and drug administration, sanitation; relating the needs for educational programs for nurses, dentists, physicians, health associates, and other health workers; and coalescing the administrative bureaucracy of health programs in the Social Security Administration, the military services, the Labor Department as well as the Health, Education, and Welfare.

Dr. Peterson considers your committee's consideration of national health insurance to be the touchstone to achieving our national priorities for a single high quality of health care for everyone, but the only result, if the result is to proffer payments on a fee-for-service basis with expensive safeguards based on means tests and fear of fraud, would be a ghastly morass of bureaucratic networks enmeshing a wastefully funded "nonsystem" of low quality care. Instead, your committee appears to us to be obliged to act on the Nation's behalf of tying the universal national health insurance principle to the implementation of a system which is responsive and responsible to the people. Thank you very much.

Mr. Rostenkowski. Thank you.

Dr. Spencer?

STATEMENT OF C. DAVID SPENCER, M.D.

Dr. Spencer. My written testimony is included in the testimony of our group which has already been submitted for the record.

I happen to have been in Chicago, Mr. Chairman, at the Group Health Association meetings when you announced that these hearings were going to take place, and it is a pleasure to be here and participate in them at this time.

I would like to just add some personal comments to give you some feeling for my underlying interests and my commitment to national health insurance as a concept.

In the mid-1960's, I worked abroad for a couple of years, and during that experience I think I was sensitized to the problems of access to health care that can exist and do in fact exist for most of the people in the world.

When I returned to this country and after I completed my training in internal medicine, I moved into a rural area and joined a federally funded health care program for a rural area in Washington State.

I was struck there by the bulk of the unmet health needs in that large population of rural America. Access to health care there in some cases was nearly as limited and in some cases more limited than the foreign population I had worked with.

Then I gradually became more and more aware of the fact that these problems were not limited to the low-income population, that the middle income population in that area and obviously in much of this country, has tremendous problems in this respect.

I experienced at close range the tremendous frustration of trying to deal with individuals who for a variety of reasons did not have coverage; for example, the thousands of self-employed farmers, people who change jobs frequently. I ran head on into the tangle of programs, migrant health programs, welfare programs, insurance programs, each with its own set of eligibility criteria which really boggle the imagination.

I met large deductibe situations, exclusions of all sorts, large copayment provisions, and so forth. I also came to realize then that the health dollars had been sprinkled as if with a small watering can over the vastness of our country.

Certainly a patchy job geographically at best, and in those areas even where Federal health programs such as the one I was with, there have been distorted inequitable distribution with many large gaps.

Recently, I took on administrative responsibility for one of the centers in a growing HMO because I am convinced that the solutions ultimately are only going to come through a reorganization of the health care system integrally linked to a universal program of national health insurance.

Moving on to the written testimony, I think that a process that is as complex as the drafting of national health insurance is likely to leave some of the pivotal issues foggy. I think, therefore it is important that we try and focus on these and realize that there has been a considerable effort by university groups, by the Federal Government, by the health care institutions, to try and cull the data and informtion from experiences in our own country which can shed some light on these issues and try and pave the way for some rational decisions about the kind of national health insurance program we should have.

It seems to me, to start with, that the purpose of a national health insurance program should be to bring about a more equitable distribution of health care and improvement of health through some economically feasible method, or restated, I think these are the socially responsible goals: equitable distribution and access, quality care, and improvement of health status and economic feasibility.

At the present time, the statistics really are clear, which statistics point out the lack of access to health care on the part of a large segment of Society.

In reference to the comments made in the panel this morning about figures, I think there are a couple of points to be made on that. One was made by Mrs. Keys and that is that most of these figures deal with coverage for hospitalization and neglect the outpatient and early care that is at least as important.

Secondly, the kind of coverage, the nature of coverage with its exclusions is also clouded over by citing overall statistics.

Now, let me just examine the statement that I made about the purpose of national health insurance and ask what specific issues this brings out.

First, in regard to equitable access and distribution are two fundamental issues. First, a choice between a universal versus categorical program. On the one hand, there are a series of bills which would define categories of people or income ranges of people who would qualify for coverage; and on the other hand, fewer numbers of bills which would provide coverage to anyone who is a resident of the United States.

Any of you who watched the TV documentary by Wiseman very recently could experience vividly the incredible absurdity that eligibility testing can achieve.

Means testing is administratively very costly, filled with loopholes and regulations which encourage deception, leave millions of citizens out because of stipulations which look fine in writing but are unfair in practice.

In previous testimony I gave in a special hearing here, Mr. Chairman, I recounted some experiences from my own work, and they are innumerable of people who did not qualify because of some kind of hitch.

There is an additional "notch" phenomenon here, this is described in the article which I have cited referring essentially to the abrupt dropoff in subsidy once the family income exceeds a certain amount.

This may be an all-or-nothing or step-by-step decrease in subsidy, I might add.

The result is the same; however, individuals so affected have an incentive to keep their income below that quantum jump point or the complete dropoff is triggered.

Programs which are directed to the unemployed, I think as a special group, are fraught with tremendous problems, definitions of what constitutes an unemployed person, how long do they have to be unemployed before they qualify, what to do with the self-employed, with questions of duration of employment, et cetera.

In our mobile society such a categorical approach to health care coverage seems particularly inappropriate. The experiences in Canada and in Great Britain have shown that access to care and use of health services by middle- and low-income persons was significantly enhanced through the introduction of universal insurance.

I would refer you to the study of the Quebec experience for further details. I have cited that as a reference in my testimony. Quite clearly, universal coverage will achieve more equitable distribution of health care than will spotty coverage for categories of people.

The second issue in the choice between private and Federal handling of the finances. Quite obviously the Federal Government would have to be called into play in a major role in order to bring about a universal, comprehensive plan and the Federal Government already has existing mechanisms for income determination and revenue collection.

Both of these issues have a direct bearing upon equitable health care and access distribution. Now I would like to turn to the questions of quality of care and the status of health.

What are the central issues in the national health insurance debates which directly impinge upon the challenge of improving health status?

I see two issues which are relevant here.

The first is the choice between a program of catastrophic coverage versus a program that covers first dollar coverage as well as catastrophic protection. There are those who argue that the way to achieve control of costs is to place a significant burden of cost-sharing on the consumer of health care.

This, they say, has a twofold effect; it acts as a deterrent to the neurotic complainer who otherwise might flood the system; and, it absorbs a substantial amount of the direct financial burden.

But what effect can such cost-sharing schemes as copayments and deductibles have upon the health of the patients?

There are two sets of studies which I would like to cite. One looks at the utilization patterns in Quebec before and after the introduction of universal health insurance. In this study it was found that middle and lower income individuals were more likely to consult the physician for significant symptoms after the introduction of health insurance than before. It is also clear from that study that there were symptoms such as a cough of 2-week duration, lingering ear infections, and so on for which these families were more likely to consult the physician after introduction of national health insurance than before.

Now there are those who argue that the way to achieve control of costs is to place significant deductibles or copayments on health care visits but it is clear from this study that following the copayment requirements, the individuals who had to pay the fee for each visit had a significantly lower rate of office visits. A second study which is perhaps even more pertinent is the one recently reported by Dr. Milton Roemer, of UCLA. This is very important because I think this tends to undermine the basic concept that cost-sharing by the patient in fact reduces costs. This was a study in California in which it was clearly shown that with the introduction of copayment requirements upon a large number of families, these families initially had a drop-off in rate of physician visits over a 9-month period, and they had a significantly lower rate of services, 30 percent lower pap smear rates, too. But the whole thing backfired because the hospitalization rate went up. It was higher with the group for which there was no copayment requirement.

The net result was an excess cost to the State of $1.250 million. Again, I have that all referenced in my statement.

The second choice which can have an effect upon the quality of care is the choice between retaining our present system of health care versus working towards and providing incentives for changing our health care system, at least in certain respects. I will briefly touch on a few of the kinds of changes which would be relevant in this context.

The recent surge in interest in prepaid group practice had brought some data out which had shown lower perinatal mortality rates and higher use of preventive services in the prepaid group in which this was examined compared with a fee-for-service group of patients. These are well known studies and as I stated before the references are in the written statement.

The prepayment mechanism can also allow for a more rational allocation of specialists which is certainly a problem of national dimension.

For example, in a recent study of surgeons' activities, it was found that within a prepaid group practice, the complex thoracic and vascular surgery was performed by the two surgeons who had the most training in those areas, in contrast to the situation in the fee-for-service medical community where such complex surgery was scattered almost randomly among the 19 surgeons with no apparent relation to their professional accreditation. Again, the references are in my statement.

I do not mean to imply that every fee-for-service practice is of inferior quality, or that prepaid mechanisms assure a higher quality, but in the situations where a comparison has been made between prepaid versus fee-for-service practice, findings I have just cited have given the prepaid groups a slight edge on that particular issue.

Finally, I would like to turn to the issue of economic feasibility. and focus on one issue which I feel is important in selecting a national health insurance plan that is not going to be an unrealistic financial drain. This is the choice between plans which place emphasis upon cost-sharing by the patient versus plans which place the major responsibility for cost-saving upon the providers of the health care. Pertinent to this choice, are the wealth of data which clearly show the major role played by the health care industry and I have cited studies. One had to do with the labor union which required that before elective surgery the patient had to be seen by a board certified surgeon. With this practice in effect the results were dramatic in that 30 percent of the proposed elective surgical procedures were judged to be unnecessary and, therefore, were not performed.

If one calculates up the expected cost of these procedures for the 1.356 union members originally thought to need surgery, the savings we calculated was well over $500,000 as well as the sparing of surgical risks.

So we see an example there in which the active role of physicians in trying to conserve costs while preserving quality and performance played a very important role.

The second example is the repeatedly shown finding that the prepaid group practice mode of health care results in reduction of hospitalization rates. the most costly part of health care. One of the references I cited here was the calculation if one were to suppose that hospital bed construction was about $50.000 per bed, which is a reasonable figure, this means that a prepaid system designed to service 30,000 enrollees would be expected to save $2.25 million. Quite obviously that kind of money could be used for earlier disease protection and preventative services.

Thus, examination of the pertinent issues, drawing on data which we have at hand would favor a universal, federally financed plan, without copayment or deductible requirements, but with significant incentives toward reorganization of overall cost containment responsibility by the providers of health care, through prospective budgeting techniques.

Financial deterrents placed upon the patients may keep them away from needed services, including preventative service, and such deterrents may prove to be far more costly to society in the long run.

And to quote the title of Dr. Roemer's article, Mr. Chairman, "Penny Wise, and Pound Foolish."

Thank you very much.

[The prepared statement follows:]

STATEMENT OF C. DAVID SPENCER, M.D.

A process as complex as the drafting of a viable national health insurance bill can quickly cloud over the fundamental issues. We can rapidly be drawn into discussions about minute details to the neglect of the key underlying concepts. It is vital that, in the course of these hearings, some sense of focus be retained, and more than that, that some strenuous attempts be made to make rational decisions based upon experiences of the past, within our own health care system. There have been, in fact, some substantial efforts by the government, by university groups, by foundations, and by health care organizations, to accumulate information which would have a direct bearing upon national policy-making decisions, and I'm sure that many of you are already familiar with some of these studies. Nevertheless, I would like to present, first of all, a general statement of purpose as to what we should be trying to achieve with a national health insurance program; secondly, specific issues which that statement raises; and finally, the information we have to help us make rational choices.

The purpose of a national health insurance program should be to bring about a more equitable distribution of health care and improvement of health through economically feasible means. Re-stated: these are the socially responsible goals: equitable distribution and access; quality care and improvement of health status; and economic feasibility. At the present time, the statistics are clear which point out the lack of access to health care on the part of a large segment of society and the magnitude of cost of a program such as Medicare, which essentially poured money into the existing system of health care.

Now let us examine this statement and ask what specific issues this brings out? First, in regard to equitable access and distribution, are two fundamental issues: The first of these is the choice between a universal versus a categorical program. On the one hand are a series of bills which define categories of people, or income ranges of people who would qualify for coverage. On the other hand are a fewer number of bills which would provide coverage to anyone who is a resident of the United States. Any of you who watched the outstanding T.V. documentary recently on our welfare system experienced the absurd tangle which an eligibility testing program can achieve. Means-testing is administratively very costly, filled with loopholes and regulations which encourage deception, and leave millions of citizens out because of stipulations which look fine in writing but are unfair in practice. I recall from my own experience over the past four years working in a federally-funded health center in a rural area, the number of poor farmworkers who did not qualify for public assistance in Washington State because they owned a small shack into which they had crammed their family. There is, in addition, the well-acknowledged "notch" phenomenon. This is well-described in an article which I would like to call to your attention, in the Milbank Memorial Fund Quarterly by Dr. Rachel Boaz of N.Y.U.[1] This refers to the abrupt drop-off in subsidy once a family's income exceeds a certain amount. This may be an all-or-nothing drop-off, or it may be a step-by-step decrease in subsidy. The net result is the same: individuals so-affected have an incentive to deliberately keep their income from rising, as they will find it hardly worthwhile to make the effort. Programs which are directed to the unemployed as a special group, are fraught with problems of definitions of what constitutes an unemployed person, with what to do with self-employed, with questions of duration of unemployment before coverage, etc. In our mobile society, such a categorical approach to health care coverage seems particularly inappropriate. Experience in Canada, and in Great Britain has shown that access to care and use of health services by middle and low-income persons was significantly enchanced through the introduction of universal insurance. I would refer you to a study of the Quebec experience which appeared in the New England Journal of Medicine, November 29, 1975 for further details.[2] Quite clearly, universal coverage will achieve a more equitable distribution of health care than will spotty coverage for categories of people.

The second issue is the choice between private and federal handling of the finances. Quite obviously, the federal government would have to be called into play in a major role in order to bring about a universal, comprehensive plan, and the federal government already has an existing mechanism for income determination and revenue collection.

Both of these issues have a direct bearing upon the equitable distribution of health care. Now I would like to turn to the questions of quality of care and status of health. What are the central issues in the national health insurance debates which directly impinge upon the challenge of improving health status? I see two issues which are relevant here:

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[1] Boaz, R. F., "Equity in Paying for Health Care Services under a National Insurance System," *Milbank Memorial Fund Quarterly*, Vol. 53, pp. 337–352, Summer 1975.

[2] Enterline, P. E., and V. Salter *et al.*, "The Distribution of Medical Services before and after 'Free' Medical Care—The Quebec Experience," *New England Journal of Medicine*, Vol. 289, pp. 1174– 1178, 1973.

The first is the choice between a program of catastrophic coverage as well as catastrophic protection. There are those who argue that the way to achieve control of costs is to place a significant burden of cost-sharing on the consumer of health care. This, they say, has a two-fold effect: (*a*) it acts as a deterrent to the neurotic complainer who otherwise might flood the system and (*b*) it absorbs a substantial amount of the direct financial burden. But what effect can such cost-sharing schemes as co-payments and deductibles have upon the health of the patients? There are two sets of studies which I would like to cite. One looks at the utilization patterns in Quebec before and after the introduction of universal health insurance. In this study [3] it was found that middle and lower income individuals were more likely to consult the physician for significant symptoms after the introduction of health insurance than before. The percentage of times that a doctor was consulted rose from 59 percent to 74 percent after. A second study which is perhaps even more pertinent is the one recently reported by Dr. Milton Roemer of U.C.L.A.[4] He and his colleagues studied a group of over 10,000 Medicaid recipients in California who were required to co-pay $1 for each physician visit and 50 cents for each prescription. They compared this group to about 30,000 Medicaid recipients who were not required to make co-payments. They followed these groups for a period of six months prior to the beginning of the co-payment requirement and for twelve months thereafter. Following the co-payment requirement, the individuals who had to pay a dollar for each office visit had a significantly lower rate of office visits. It is important to note, however, that they had a 30-percent lower rate of Pap smears as well. This latter finding is in itself a cause for concern. However, of even more concern was the subsequent finding that, during the nine months following imposition of the co-payment requirement, the co-paying group had higher hospitalization rates, even though their office visit rates were less. Originally, the State had imposed the co-payment requirement in order to save its funds. This is the thinking behind many of the bills being considered here which include co-payment requirements. The plan backfired, however, because of the increased hospitalizations. In the long run, the co-payment requirement ended up as an excess cost to the State estimated at $1,230,000. Thus, the deterrent to early health care may in the long run be more costly to society, not less. Dr. Roemer's title of the article was appropriate: "Penny-Wise and Pound-Foolish."

The Second choice which can have an effect upon the quality of care is the choice between retaining our present system of health care versus working towards and providing incentives for changing our health care system, at least in certain respects. I will briefly touch on a few of the kinds of changes which would be relevant in this context. The recent surge in interest in pre-paid group practice had brought some data out which had shown lower perinatal mortality rates and higher use of preventive services in the prepaid group in which this was examined compared with a fee-for-service group of patients.[5] [6] The pre-payment mechanism can also allow for a more rational allocation of specialists for a population group than does fee-for-service. For example, in a recent study of surgeons' activities, it was found that, within a pre-paid group practice, the complex thoracic and vascular surgery was performed by the two surgeons who had the most training in those areas, in contrast to the situation in the fee-for-service medical community, where such complex surgery was scattered almost randomly among the nineteen surgeons with no apparent relation to their professional accreditation.[7] I do not mean to imply that every fee-for-service practice is of inferior quality, or that pre-paid mechanism issures high quality, and in the situations where a comparison has been made between pre-paid versus fee-for-service practices, findings as I have just cited have given the pre-paid groups a slight edge on that particular issue.

Finally, I would like to turn to the question of economic feasibility, and focus on one issue which I feel is important in selecting a national health insurance plan that is not going to be an unrealistic financial drain. This is the choice between plans which place emphasis upon cost-sharing by the patient versus plans which place the major responsibility for cost-saving upon the providers of the health care. Pertinent to this choice, are the data which clearly show the major role played by the health care industry in determining not only the direct cost of care, but also the demand for health care. I would like to cite an example of this. Two labor unions in New York City establish a policy that if a member's private physician had decided that he or she had to have an elective operation performed, he would have to obtain a second opinion from a board-certified surgeon who had been appointed by the union to render such decisions. Through this process, 30 percent of the proposed elective surgical procedures were judged to be unnecessary and were therefore not performed. The result, for the 1,356 union members originally thought to need surgery was a savings of over $500,000, as well as the sparing of surgical risks.[8]

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[3] *Ibid.*

[4] Roemer, M., and C. E. Hopkins *et al.*, "Copayments for Ambulatory Care: Penny-wise and Pound-foolish," *Medical Care XIII*, No. 6, pp. 457–466, June 1975.

[5] Roemer, M., and R. W. Heatherington et al., "Health Insurance Effects: Services, Expenditures, and Attitudes under Three Types of Plans," Ann Harbor; University of Michigan School of Public Health, 1973.

[6] Donabedian, A., "An Evaluation of Prepaid Group Practice," Inquiry, vol. 6, pp. 3–27. 1969.

[7] Hughes, F. F. X., and V. R. Fuchs et al., "Surgical Work-Loads in a Community Practice," Surgery, vol. 71, pp. 315–27, 1972.

A second example is the repeatedly-shown finding that pre-paid group practice mode of health care results in reduction of hospitalization rates, the most costly part of health care. The well-known study of the utilization patterns of federal employees enrolled in a number of different types of insurance and prepaid practice options showed families which selected traditional insurance plans used 924 days of hospitalization per 1000 people per year whereas enrollees in pre-paid practice plans (i.e. HMO's) had a hospitalization rate of only 471 days per year.[9] If one translates this into costs for hospital bed construction, figuring $50,000 per bed, this means that a pre-paid system designed to serve 30,000 enrollees would be expected to save 2.25 million dollars in capital investment otherwise spent for hospital bed construction.[10] Such funds could be diverted to increased preventive and early treatment services.

Thus, examination of the pertinent issues, drawing on date which we have at hand at the present time, would favor a universal federally financed plan, without co-payment or deductible requirements, but with significant incentives towards re-organization of over-all cost-containment responsibility by the providers of health care, through prospective budgeting techniques. Financial deterrents placed upon the patients may keep them away from needed services, including preventive services, and such deterrents may prove to be far more costly to society in the long run.

Mr. ROSTENKOWSKI. The committee will suspend for 15 minutes because there will be two rollcalls on the floor of the House.

Dr. Spencer, if you have finished, Dr. Lynch will be next.

We will suspend for about 15 minutes.

[A brief recess was taken.]

Mr. ROSTENKOWSKI. The committee will resume.

Dr. Lynch?

STATEMENT OF ANNETTE LYNCH, M.D.

Dr. LYNCH. Mr. Chairman, you have my written testimony. You have my curriculum vitae. I think it is sufficient to say that for purposes of these proceedings, that I am a physician, I got my medical training in Australia; I had worked in England in the National Health Service both in general practice and in public health, and have been engaged in a variety of health and public health concerns in this country of which I am now a citizen.

At this time in the development of health services delivery in the United States there is valid concern that the bed we fashion today may not prove so comfortable as we lie in it tomorrow. Particularly there are fears regarding what may happen as a result of greater

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[8] McCarthy, E. G., and G. W. Widmer, "Effects of Screening by Consultants on Recommended Elective Surgical Procedures," New England Journal of Medicine, vol. 291, pp. 1331–35, 1974.

[9] U.S. Department of Health, Education, and Welfare. 'The Federal Employees Health Benefits Program; Enrollment and Utilization of Health Services," 1961–68, (OM–2482). Rockville, Md., HSMHA, 1971.

[10] Dorsey, J. L., "Prepaid Group Practice and the Delivery of Ambulatory Care," New England Journal of Medicine, vol. 291, pp. 361–63.

Government involvement in the delivery of medical and health services. Some of these fears have been fed, and are being fed, by distorted stories and news items from countries which have government-operated systems of national health insurance or national health services.

I would like to address this matter of Government involvement in health services delivery from two angles: First, describing some of the developments in the totally Government-operated school health program of Pennsylvania in which I work; and second, relating some of my experiences in England working under the National Health Service.

The school health program in Pennsylvania consists of medical, dental, and nursing services which the 505 school districts of the Commonwealth are required by the law to provide for all children of school age. The content of services is specified by the State department of health. Funds for the program are 50 percent State and 50 percent local.

School health services proved their worth in the early decades of this century when they halved school absenteeism by reducing the acute and chronic communicable diseases of that era; however, it is now recognized that today's student population, spared the ravages of many of yesterday's diseases which have disappeared, have now other health problems which impair their function.

School health programs in Pennsylvania and other States thus have found themselves offering services from their past which are ineffective in meeting the health needs of today's students and which also force current professional staff into the inefficiency of outdated roles. Little wonder that consumer and fiscal agencies have asked what is accomplished by a program costing the Pennsylvania taxpayers $26 million per year.

The focus of overall responsibility for the total system of school health services resides in the Pennsylvania Department of Health whose general mandate is the "duty * * * to protect the health of the people * * * to determine and employ the most efficient and practical means for the prevention and suppression of diseases." Specifically, in regard to school health, the department of health determines the programs and standards of services to be provided by the local school districts with reimbursement by the State.

In the past 2 years, the department of health has analyzed the school health services system, clearly identified its objectives to increase health and to decrease disease in the population served, and has developed mechanisms by which local school districts plan, within State guidelines, programs of health services to meet the health needs of their local student population.

Freed of old stereotypes and strictures regarding appropriate services, a number of pilot and demonstration projects have been planned and are in varying stages of implementation. One of the most promising models, affecting both service content and staff roles, capitalizes on the major, but underutilized, resource of the school health field, the professional school nurse. With some additional education, the school nurse becomes a "school nurse practitioner," who takes over the physical examination of students and finds six times more defects than her predecessor, the school physician.

She adds the new function of the medical history which is superior to the physical examination in discovering health problems, particularly those relevant to classroom function; with additional means to assess and monitor the health of students she uses the "problem-oriented record" to insure accountability in problem resolution. The school nurse practitioner, playing a central role as the assessor and manager of the child's school health in a close relationship with parent and involved agencies, is assisted by an aide-technician (usually a high school graduate) who performs 75 percent of the nurse's former functions of clerical work, first aid and screening tests, by a physician who instead of many mindless hours as screener of hundreds of well children spends a lesser amount of his limited time in the highly satisfying role of pediatric consultant to the school nurse practitioner in the management of children with difficult problems. There is a diagram in my presentation which shows how the roles have changed in the school health program as nurses have moved on to take over functions formerly done by physicians. Physicians have moved to do things that only they can do with their kind of training and aides have moved into the picture to take over the nurse's functions.

In summary, these new programs revolving around optimal roles of nurses, physicians, and aides have achieved a high level or parental involvement; 92 to 97 percent of parents are coming into the school to be involved directly with the nurse-practitioner in the health care of their children, find more student health problems with greater relevance to education, and provide mechanisms to obtain satisfactory problem resolution. All is accomplished with a record system documenting program quality, effectiveness, and efficiency, while providing such data on the health status of the population as needed by those planning preventive programs.

The costs of the new program for the school district are the same as the old program. The central administrative costs in the past 2 years during which the plan has been articulated and implementation begun in 10 percent of school districts has been 0.1 percent of the total budget. These costs are projected to increase to 0.7 percent during the next few years of maximal implementation and then decrease to a maintenance level of about 0.5 percent.

My experiences in the English National Health Service rank among the most satisfying and pleasurable of my professional life. I began work in a general practice in the Midlands (Derbyshire) on the day following my arrival from 2 years in a fine U.S. university hospital. In those days I was studying gastroenterology and it was before medicare and medicaid and a large number of the people attending the procedure could not afford the X-rays, diagnostic procedures, medications or hospitalizations which were our stock in trade for diagnosis and treatment. The faces of those who do not have money for the medical care they know they need, and want to have, can haunt one for a long period of time, as can the feeling of helplessness when the patient's lack of means prevents the physician from exerting knowledge and skill to the full benefit of the patient. Under the English National Health Service (NHS), I immediately learned, one is free to practice medicine according to the best standards and not according to what can be afforded. Under the National Health Service, one may order laboratory tests, X-rays, consultations with specialists on an in-patient or out-patient or home-visit basis, drugs, appliances and hospitalization and without worry that the patient might find it too difficult to pursue the course outlined.

When looking at the system of health services in the United States and England, one finds that the elements are very similar—similar hospitals, specialists, public health and community services, medical education. So the question becomes what are the real and basic differences? There appear to be two. First, the mechanisms to pay for medical care are in England Government-sponsored, universal, comprehensive; while in the United States the varied public and private schemes provide a fragmented patchwork which does not cover all persons for all services.

Second, in England, as opposed to the United States, the elements are drawn into a system for which there is a responsible agent, the Minister of Health, who, under the National Health Service Act of 1946, has the duty "to promote the establishment in England and Wales of a comprehensive health service designed to secure improvement in the physical and mental health of the people of England and Wales and the prevention, diagnosis and treatment of illness."

There is no doubt that the National Health Service in England has accomplished its major objectives. In a system in which there is no compulsion to join, 97 percent of the population have, and where there is freedom to engage in private practice such private practice is infinitesimal in volume. People choose their family doctors or general practitioners, who provide the link with all other elements of the National Health Service. The traditional patient-doctor relationship has been safeguarded. All residents of England have financial and geographic access to a comprehensive range of medical care services.

At what price has this success in delivery of health services been brought? Surprisingly, a minimal degree of organization and bureaucracy has been the experience of the National Health Service. At the outset it was decided that "the degree and kind of public organization needed to insure that the service was properly provided, that resources were properly distributed and that scope was given to new methods and developments" should be accomplished with "no unnecessary uprooting of established services, but that good existing facilities and experiences should be used and that what was good should be preserved, adapted, extended, welded together and incorporated into a large comprehensive organization." Thus has England preserved and strengthened its systems of family doctors as the deliverers of primary medical care and consultants as the deliverers of specialty care.

The bureaucratic facts of the National Health Service are worth noting as most who think of Government involvement in any venture immediately conjure up a nightmare image of massive bureaucracy. The administrative costs of the National Health Service are 3 percent of the total expenditure; civil servants of the Ministry of Health number less than 6,000 and there are no civil servants among the over one-half million persons employed in the National Health Service—mostly hospitals. There are about 10,000 persons who serve in a voluntary capacity on the boards and committees which govern the three branches of the NHS—hospitals, general practitioners, public health; there are about 30 official forms in the NHS but less than 10 are in constant use. They include: Medical record forms; prescription forms;

request for maternity services; request for eye services; medical certificate of incapacity for work; and application to join a doctor's list or transfer to new doctor.

Most of these would be needed if the National Health Service did not exist. Physicians are relieved of the paperwork surrounding the billing of patients and in addition, patients' medical records are transferred with them as they move from one family doctor to another.

An authoritative observer of the National Health Service has written:

> In the hospital service * * * there is no hierarchy on the medical or professional side, but advice is fed into the administration through the advisory staff at the centre, the administrative medical officers at the regional board level and staff medical committees at hospital level. It would appear thus that bureaucracy has entered the National Health Service only mildly at professional levels.

Neither has success of the National Health Service been bought at staggering costs: The percentage of gross national product consumed by health services increased in England but less than the United States and most other countries; Hospital admissions, numbers of physicians, and modern diagnostic and treatment devices have risen; Loss of innovation has not been observed (Government-sponsored medical research has grown faster than research sponsored by the pharmaceutical industry or private trusts and charities). The National Health Service through permissive legislation has fostered innovation which in the matter of health centers and the role of the general practitioner is just beginning to yield exciting results. Indeed, the whole National Health Service is in the process of reorganization after prolonged debate both within and outside the service. The reorganization aims to unite the three aspects of the old National Health Service (hospitals, general practice public health) into local units with greater responsibilities in local planning, preventive programs, more staff input and a larger consumer voice, especially for those consumers usually denied representation—the aged, the disabled, the chronically ill. These people make up a large segment of those served by the National Health Service and all health services. in these days of older populations with chronic diseases.

My experience in the English National Health Service and the Pennsylvania school health program have led me to certain conclusions regarding the nature of government in health services delivery.

1. To insure that a health system moves toward desired ends, and that all its parts are geared to the same ends, it is necessary to have some person, or some agency, responsible for the total system.

In other words, if the objective is for all in society to have access to needed medical services, there must be somebody which can be held accountable should that not be so.

2. The total system must be involved. Parts of the health care system are so independent that concentration on one distorts the total picture. Thus, in Canada National Health Insurance, by covering the expensive costs of acute hospital care and physicians' fees, has increased the use of these services and thus increased the cost of National Health Insurance. More comprehensive coverage of all medical care costs as seen by the Canadian Health Services, among others, is seen as necessary to prevent distorted use caused by a distorted payment mechanism.

Similar cost-spiraling experiences in the United States with the hospital limited payment mechanisms of health insurance and medicare should alert all to the dangers of tinkering with one aspect of the system as proposed by so-called "catastrophic coverage."

There is another point: as the English are able, because of the overall responsibility for the National Health Service exerted by the Ministry of Health, to reorganize to obtain more local planning for, among other things, preventive programs, the United States is faced by those who wish to deal with only one aspect of health services—the expensive medical care aspect. The noted physician, Dr. Franz J. Ingelfinger, recently pointed out the unethical implications of such concentration on one aspect of the system alone:

> An important circumstance not appreciated by the public but well known to the doctor is the fact that longevity and infant mortality are relatively little influenced by the specifics of medical care, but depend principally on lifestyles, nutrition, and sanitary practices. The huge amount of money spent in the United States on health care is attributable principally to political pressures that ignore prevention but generously allocate resources to the treatment of terminal or near-terminal disease, which may prolong life only briefly.

3. The third point I wish to make is the popular image of Government involvement in health services as of necessity requiring massive bureaucracy, centralized decisionmaking, bloated costs, mountains of paperwork, interference in the clinical encounter, and deadening of creative innovation is simply not true.

There is no doubt that one can run any bureaucratic operation as described above, but the point is that it does not have to be so. There are examples to prove it and there are the teachings of modern management which are finding ready applicability today in the field of health services.

With eyes clearly focused on their objectives—namely, the improved health status of the population—health care systems may be operated by those with ultimate responsibility in a manner designed for optimal effectiveness, efficiency, constant experimentation, staff and consumer involvement in decisionmaking, confidentiality preserved, decreased paperwork, improved records, and small central bureaucracies.

It is of necessity the Government must be involved in insuring for each of its citizens the right to health services. Such Government involvement in the total health care system as proposed in the Kennedy-Corman and Young bills deserves close attention from those not fearful of the words "Government involvement" but knowledgeable of what those words may mean and have already demonstrated. Thank you.

[The prepared statement of Dr. Lynch follows:]

STATEMENT OF ANNETTE LYNCH, M.D.

My name is Annette Lynch. I am a physician and currently hold the position of Director, School Health Program, Pennsylvania Department of Health. I am a U.S. citizen but was born in Australia where I graduated in Medicine from the University of Sydney in 1960. For 3½ years I pursued a career in clinical and research Gastroenterology at the universities of Sydney and Pennsylvania. A concern for health services delivery took me to England in 1965 where I stayed for over two years; obtained a Diploma in Public Health at the University of Bristol, worked in three general practices in the Midlands and Essex, and served as Assistant County Medical Officer of Health in Essex. Since my return to the U.S.A. in 1967 I have held the following positions: Assistant Professor of Epidemiology Medical College of Pennsylvania; Associate Professor of Community Medicine, Hahnemann Medical College; and Associate Director of Health Services, School District of Philadelphia.

At this time in the development of health services delivery in the United States there is valid concern that the bed we fashion today may not prove so comfortable as we lie in it tomorrow. Particularly there are fears regarding what may happen as a result of greater government involvement in the delivery of medical and health services. Some of these fears have been fed, and are being fed, by distorted stories and news items from countries which have government-operated systems of national health insurance or national health services.

I should like to address this matter of government involvement in health services delivery from two angles: first, describing some of the developments in the totally government-operated school health program of Pennsylvania; and second, relating some of my experiences in England working under the National Health Service.

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School health services proved their worth in the early decades of this century when they halved school absenteeism by reducing the acute and chronic communicable diseases of that era however, it is now recognized that today's school student population, spared the ravages of many of yesterday's diseases, have other health problems which impair their lives, educational function and future.

School health programs in Pennsylvania, and other states, thus have found themselves offering services from their past which are ineffective in meeting the health needs of today's students and which also force current professional staff into the inefficiency of outdated roles. Little wonder that consumer and fiscal agencies have asked what is accomplished by a program costing the Pennsylvania taxpayers $26 million per year.[1]

The focus of overall responsibility for the total system of school health services resides in the Pennsylvania Department of Health whose general mandate is the "duty * * * to protect the health of the people * * * to determine and employ the most efficient and practical means for the prevention and suppression of diseases". Specifically, in regard to School Health, the Department of Health determines the programs and standards of services to be provided by the local school districts with reimbursement by the state.

In the past two years the Department of Health has analysed the school health services system, clearly identified its objectives to increase health and to decrease disease in the population served, and has developed mechanisms by which local school districts plan, within state guidelines, programs of health services to meet the health needs of their own local student population.

Freed of old stereotypes and structures regarding appropriate services a number of pilot and demonstration projects have been planned and are in varying stages of implementation. One of the most promising models, affecting both service content and staff roles, capitalizes on the major, but underutilized, resource of the school health field—the professional school nurse. With some additional education the school nurse becomes a "school nurse practitioner" who takes over the physical examination of students and finds over six times more defects than her predecessor, the school physician. She adds the new function of the medical history which is superior to any physical examination in discovering health problems, particularly those relevant to classroom function; with additional means to assess and monitor the health of students she uses the "problem-oriented record" to ensure accountability in problem resolution. The school nurse practitioner, playing a central role as the assessor and manager of the child's school health in a close relationship with parent and involved agencies, is assisted by an aide-technician who performs 75 percent of the nurse's former functions of clerical work, first aid and screening tests, and by a physician who instead of many mindless hours as screener of hundreds of well children spends a lesser amount of his limited time in the highly satisfying role of pediatric consultant to the school nurse practitioner in the management of children with difficult problems. (see diagram)

In summary, these new programs revolving around optimal roles of nurses, physicians and aides have achieved a high level of parental involvement (92–97 percent), find more student health problems with greater relevance to education and provide mechanisms to obtain satisfactory problem resolution. All is accomplished with a record system documenting program quality, effectiveness and efficiency, while providing such data on the health status of the population as needed by those planning preventive programs.

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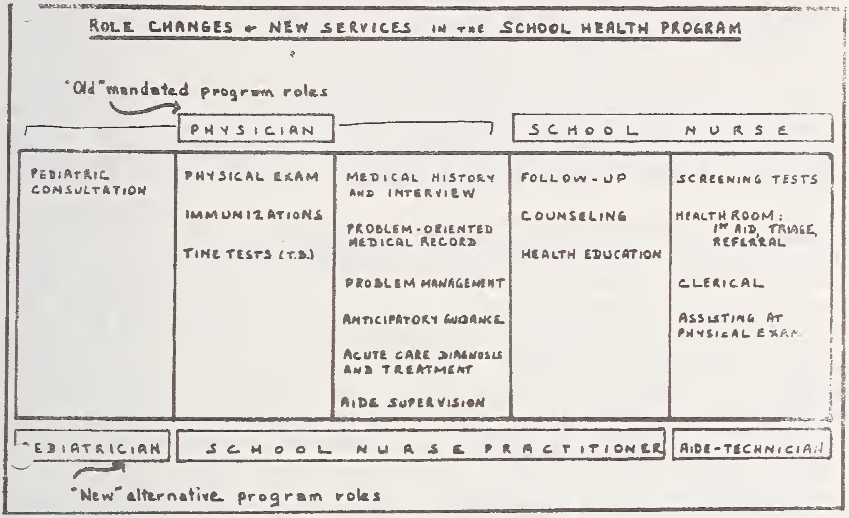
[1] "A Program Audit Report on the School Health Services Programs 1911–1970 in Pennsylvania." Division of Program Audit, Budget Bureau, Office of Administration, Governor's Office, July 23, 1970.

The costs of the new program for the school district are the same as the old. The central administrative costs in the past 2 years during which the plan has been articulated and implementation begun in 10 percent of school districts has been 0.1 percent of the total budget. This is projected to increase to 0.7 percent during the next few years of maximal implementation and then decrease to a maintenance level of about 0.5 percent.



ROLE CHANGES & NEW SERVICES IN THE SCHOOL HEALTH PROGRAM

"Old" mandated program roles

PHYSICIAN			SCHOOL NURSE	
PEDIATRIC CONSULTATION	PHYSICAL EXAM IMMUNIZATIONS TINE TESTS (T.B.)	MEDICAL HISTORY AND INTERVIEW PROBLEM-ORIENTED MEDICAL RECORD PROBLEM MANAGEMENT ANTICIPATORY GUIDANCE ACUTE CARE DIAGNOSIS AND TREATMENT AIDE SUPERVISION	FOLLOW-UP COUNSELING HEALTH EDUCATION	SCREENING TESTS HEALTH ROOM: 1st AID, TRIAGE, REFERRAL CLERICAL ASSISTING AT PHYSICAL EXAM
EDIATRICIAN	SCHOOL NURSE PRACTITIONER			AIDE-TECHNICIAN

"New" alternative program roles

My experiences in the English National Health Service rank among the most satisfying and pleasurable of my professional life. I began work in a general practice in the Midlands (Derbyshire) on the day following my arrival from 2 years in a fine U.S. university hospital. In those days before Medicare and Medicaid a large number of patients who attended the Gastroenterology clinic could not afford the x-rays, diagnostic procedures, medications or hospitalizations which were our stock-in-trade for diagnosis and treatment. The faces of those who do not have money for the medical care they know they need, and want to have, can haunt one for a long time, as can the feeling of helplessness when the patient's lack of means prevents the physician from exerting knowledge and skill to the full benefit of the patient. Under the English National Health Service (N.H.S.), I immediately learned, one is free to practice medicine according to the best standards and not according to what can be afforded. Under the N.H.S. one may order laboratory tests, x-rays, consultations with specialists on an in-patient or out-patient or home-visit basis, drugs, appliances and hospitalization and without worry that the patient might find it too difficult to pursue.

When looking at the system of health services in the U.S.A. and England one finds that the elements are very similar—similar hospitals, specialists, public health and community services, medical education—so the question becomes what are the real basic differences. There appear to be two differences; first, the mechanisms to pay for medical care are in England government-sponsored, universal, comprehensive, while in the U.S. the varied public and private schemes provide a fragmented patchwork which does not cover all persons for all services.

Second, in England, as opposed to the U.S., the elements are drawn into a system for which there is a responsible agent, the Minister of Health, who, under the National Health Service Act of 1946 has the duty "to promote the establishment in England and Wales of a comprehensive health service designed to secure improvement in the physical and mental health of the people of England and Wales and the prevention, diagnosis and treatment of illness."[2]

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[2] Ministry of Health. "The National Health Service—Summary of Early History and Main Features," July 1965.

There is no doubt that the N.H.S. has accomplished its major objectives. In a system in which there is no compulsion to join 97 percent of the population have, and where there is freedom to engage in private practice such private practice is infinitesimal in volume. People choose their family doctors (general practitioners) who provide the link with all other elements of the N.H.S. The traditional patient-doctor relationship has been safeguarded. All residents of England have financial and geographic access to a comprehensive range of medical care services.

At what price has this success in delivery of health services been bought? Surprisingly a minimal degree of organization and bureaucracy has been the experience of the N.H.S. At the outset it was decided that "the degree and kind of public organization needed to ensure that the service was properly provided, that resources were properly distributed and that scope was given to new methods and developments" should be accomplished with "no unnecessary uprooting of established services, but that good existing facilities and experiences should be used and that what was good should be preserved, adapted, extended, welded together and incorporated into the larger comprehensive organisation." [2] Thus has England preserved and strengthened its systems of family doctors as the deliverers of primary medical care and consultants as the deliverers of specialty care.

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Most of these would be needed if the N.H.S. did not exist. Physicians are relieved of the paperwork surrounding the billing of patients and patients' medical records are transferred with them as they move from one family doctor to another.

An authoritative observer [5] of the N.H.S. has written: "In the hospital service . . . there is no hierarchy on the medical or professional side. but advice is fed into the administration through the advisory staff at the centre, the administrative medical officers at the Regional Board level and staff medical committees at hospital level. It would appear thus that bureaucracy has entered the National Health Service only mildly at professional levels."

Neither has success of the N.H.S. been bought at staggering costs (the percentage of Gross National Product consumed by health services increased in England but less than the U.S. and most other countries) [6] reduction in services (hospital admissions, numbers of physicians, and modern diagnostic and treatment devices have risen),[7] loss of innovation (government sponsored medical research has grown faster than research sponsored by the pharmaceutical industry or private trusts and charities).[8] The N.H.S. through permissive legislation has fostered innovation which in the matter of health centers and the role of the general practitioner is just beginning to yield exciting results.[7] Indeed, the whole N.H.S. is in the process of reorganization after prolonged debate both within and outside the Service. The reorganization [9] aims to unite the three aspects of the old N.H.S. (hospitals, general practice public health) into local units with greater responsibilities in local planning, preventive programs, more staff input

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[3] Ministry of Health. 'Misconceptions About the National Health Service," July 1965.

[4] Office of Health Economics, "The Cost of the N.H.S.," Information Sheet No. 24, March 1974.

[5] Peters, R. J., "Health Services Administration—A Source Book." Chapter XI. "Administration and Management of Hospitals," Livingstone, Edinburgh, 1965. p. 400.

[6] Office of Health Economics, "International Health Expenditure," Information Sheet No. 9, September 1970: Information Sheet No. 22. May 1973.

[7] Office of Health Economics, "The Work of Primary Medical Care," White Crescent Press, Luton, June 1974.

[8] Office of Health Economics. "Expenditure on Medical Research," Information Sheets No. 2, July 1967; No. 12, May 1971; No. 25, April 1974.

[9] Office of Health Economics. "The N.H.S. Reorganization." White Crescent Press, Luton, March 1974. London Sunday Times, "National Health Service," May 13 and May 20, 1973.

and a larger consumer voice, especially for those consumers usually denied representation—the aged, the disabled, the chronically ill who make up a large segment of those served by the N.H.S., and all health services, in these days of older populations with chronic diseases.

My experiences in the English National Health Service and the Pennsylvania School Health Program have led me to certain conclusions regarding the nature of government in health services delivery.

1. To ensure that a health system moves towards desired ends, and that all its parts are geared to the same ends, it is necessary to have some person, or some agency, responsible for the total system.

In other words, if the objective is for all in society to have access to needed medical services then there must be some body which can be held accountable should that not be so.

2. The total system must be involved. Parts of the health care system are so interdependent that concentration on one distorts the total picture. Thus in Canada National Health Insurance, by covering the expensive costs of acute hospital care and physicians' fees, has increased the use of these services and thus increased the costs of N.H.I. More comprehensive coverage of all medical care costs is seen as necessary to prevent distorted use caused by a distorted payment mechanism.[10]

Similar cost-spiralling experiences in the U.S. with the hospital limited payment mechanisms of health insurance and Medicare should alert all to the dangers of tinkering with one aspect of the system as proposed by so-called "catastrophic coverage".

There is another point: as the English are able, because of the overall responsibility for the N.H.S. exerted by the Ministry of Health, to reorganize to obtain more local planning for, among other things, preventive programs the U.S. is faced by those who wish to deal with only one aspect of health services—the expensive medical care aspect. The noted physician Dr. Franz J. Ingelfinger[11] recently pointed out the unethical implications of such concentration: "An important circumstance not appreciated by the public but well known to the doctor is the fact that longevity and infant mortality are relatively little influenced by the specifics of medical care, but depend principally on life-style, nutrition, and sanitary practices. The huge amount of money spent in the United States on health care is attributable principally to political pressures that ignore prevention but generally allocate resources to the treatment of terminal or near-terminal disease, which may prolong life only briefly."

3. The popular image of government involvement in health services as of necessity requiring massive bureaucracy, centralized decision-making, bloated costs, mountains of paper-work, interference in the clinical encounter, and deadening of creative innovation is simply not true.

There is no doubt that one can run any bureaucratic operation as described above but the point is that it does not have to be so. There are examples to prove it and there are the teachings of modern management which are finding ready applicability today in the field of health services.

With eyes clearly focused on their objective, namely the improved health status of the population, health care systems may be operated by those with ultimate responsibility in a manner designed for optimal effectiveness, efficiency, constant experimentation, staff and consumer involvement in decisionmaking, confidentiality, decreased paper-work, improved records and small central bureaucracies.

It is of necessity the government must be involved in ensuring for each of its citizens the right to health services. Such government involvement in the total health care system as proposed in the Kennedy-Corman and Young bills deserves close attention from those not fearful of the words "government involvement" but knowledgeable of what those words may mean and have already demonstrated.

Mr. Cotter [presiding]. Thank you very much, Dr. Lynch. Father Ehrens, you may proceed.

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[10] Testimony of Bette Stephenson, M.D., Past President Canadian Medical Association, to Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, Sept. 12, 1975.

[11] Ingelfinger, F. J., "Special Report on Medicine" in "What is Happening in Ethical Standards in America?" Saturday Review, Nov. 1, 1975.

STATEMENT OF FATHER RICHARD EHRENS

Father EHRENS. Mr. Chairman, thank you for this opportunity to share my experience and convictions.

I speak today on behalf of consumer participation in the planning, policymaking, and evaluative process on every level of public health insurance programs. The consumer, as I refer to him today, is that person who is served by a system of delivery and in no way derives his income from that system or its allied fields.

I state my strong conviction at the very beginning of my testimony because it is a conviction that has been learned, tested, and reinforced over 17 years of practical experience in the poverty areas of Chicago. The past 5 years, especially, have brought me into direct contact with both legal services and health delivery systems designed by your 314 E legislation and placed under the auspices of OEO and DHEW, respectively. Your intent was to best spend the allotted tax dollars to provide services to the poor citizens of our Nation.

These programs have done immeasurable good across our country. Yet, only the crassly inexperienced commentator would say they are trouble-free and running with perfect effectiveness. I guarantee that many of the problems you know of, and I see daily, would be corrected if you would listen to and legislate in accord with the message I bring today. Consumers across the Nation want an effective voice in any and all delivery systems designed to serve their needs.

The consumer has an expertise regarding his needs for which there is no substitute. No provider, however well intentioned he may be, can ever adequately and with sufficient sensitivity assess the needs of the consumer, especially the impoverished consumer. You must be a part of the situation to be able to fully comprehend it. A ridiculous example would be having a group of sincere, honest, and businesswise taxpayers study your office operations and then make final and irrevocable decisions regarding every detail of your secretarial staffs. Imagine the problems that would develop and how both you and your staff would feel. The analogy limps but the message is there. I am not being facetious. Believe me, the consumer does want an effective voice just as much as you would in this example I have given.

The affluent consumer has greater range of choice because he, unlike his poorer counterpart, can take his money elsewhere—this is a negative protest, but an effective protest just the same. The poor person has no choice where he has no voice. He is frustrated and helpless at a time and in a situation where his spirits are lowest—when he is sick or suffering. His helplessness in the situation intensifies his pain, be it physical or mental. Try, if you can, to put yourself in his shoes. Then, when you do, realize that you are aided only by your imagination. If you have been in the situation, I need press my point no further.

When and where the consumer's voice is effective, I promise that the good intent of your legislation will best be served. It makes obvious good sense that the consumer will do his very best to insure maximum efficiency in a system serving him. His self-interest, alone, demands that he seek constant improvement in the system, as well as insure an honest and efficient use of the funds available.

A further supportive argument for effective consumer voice is that suspicion and mistrust will be allayed. People in poverty areas, in order to survive, become cautious and wary. Providers, whether they are storekeepers, doctors, or lawyers, just as much as the footsteps behind me on the street, are an object of suspicion until I know I can control the situation. Again, the consumer's voice must be effective.

Specifically, I urge these four ideals:

1. Effective legislation in this area will provide that the consumers (again I stress consumer, means one whose income does not derive from the system) constitute a majority on true governing boards, having true policymaking, planning, and evaluating roles, at every level, national, State, and local. Less than a majority can result in a de facto tokenism resulting in impotence. Mere advisory boards lack sufficient power, focus, and responsibility to be truly effective.

2. Provision should be made, based on the principle of accountability, that both providers and consumers have available grievance and appeal mechanisms, with the above-mentioned boards as the final court of appeal.

3. Also, because consumers, however well aware they are of needs, have relatively little experience to date in the technicalities of these areas, your legislation should provide opportunity and means for education concerning the language and complexities of the system as well as the professional staff backup which is responsible to these consumers.

4. Finally, where the low-income consumer, especially, is involved, adequate financing for expenses incurred must be provided to insure his full participation.

No bill currently before you perfectly meets all these ideals.

The Health Security Act of 1975 (H.R. 21; S. 3, the Corman-Kennedy bill) is excellent in its declaration of purpose and has all the ideals I propose above with the one frailty, that the consumers are in a merely advisory capacity. I repeat, in my experience I have found that advisory boards are ineffective.

First, advisory boards have no real power.

Second, advisory boards do not assume true responsibility for their advice. Only a governing board or board of trustees feels the full weight of its responsibilities because of the legal and social liabilities which ensue. This responsibility assures the fulfillment of home work that you know yourself is so very demanding.

Third, mere advisory boards have a scatter shot focus or no focus at all. In giving advice, you can go all over the lot with no limitations or direction. Advisory boards are ulcer factories for executive directors because advisers are in and out of everything with complete abandon. It is difficult enough to convince governing boards and trustees of the distinction between policy and implementation but, believe me, it is impossible to convince an advisory board of that distinction.

I would welcome pursuing these and many other weaknesses inherent in advisory boards that experience has taught me.

Regarding section 121 of H.R. 21 and the establishment of the Health Security Board, I would hope you would include requirement of at least one, preferably two, of that board's members be qualified and experienced client members of a successful governing board. Such people do exist, can be found, and are available. I would ask for explicit inclusion of such persons in section 121 (f) and (g).

I would also hope that the National Health Security Advisory Council in section 125 be established rather as a regulatory board of trustees which can hold the Health Security Board truly accountable. If the Health Security Board would be accountable to the Council, then appointment to the Council should not be a matter of recommendation of that board. Mutatis mutandis. The same amendments should be made to section 126 regarding regional and local councils. I do support the provisions of the professional and technical advisory committees of section 127.

The Comprehensive National Health Care Act of 1975 (H.R. 6283—the Young bill is good in the percentage of consumers it requires on the area health services boards. These boards should be truly regulatory and statutory with power to assure compliance. I submit that the bill is extremely weak in the mode of determining who serves on said boards. There are severe limitations intrinsic in any such board when its composition is dependent "on the recommendation of elected legislative bodies of such counties or independent cities." Political control and its inherent problems should obviously warn against this method of selection. I would offer a method along the following lines:

1. Hospitals and clinics who have community clients on their boards of trustees should present a list of effective persons from such trustees.
2. The regional planning agencies, known in current legislation as the "B" agencies, should prepare a ballot of acceptable candidates for the board. It is extremely important that these "B" agencies be totally free of any political pressure or control or else we will be right back in the very trap we are trying to avoid.
3. Finally, registered consumers should elect the members of those boards from the ballots so prepared.

The above is a mere model that you and your staffs should explore, research, consult on, and refine into the legislation you finally approve.

I would like here to say that great care should be taken in selection of mode of protection for consumers so as to avoid patronage and control. Far too often he who picks the committee has already made the decision.

Now the National Health Care Services Reorganization Act (H.R. 1, which is the Ullman bill) has good provisions regarding the National Health Services Advisory Council, but again it is merely advisory to the Secretary of Health. The seven assistant secretaries of section 201(c) should include persons who are experienced consumer board members.

As you would expect, regarding the National Health Services Advisory Council, section 213, I advise a true board of trustees with the suggested composition not less than one-half being representatives of consumers of such services.

As far as consumer participation is concerned, I find the Corman-Kennedy bill the most satisfactory. I do, however, sincerely urge you to incorporate the amendments, especially regarding advisory boards, that I have advised above.

In short, I simply repeat that for us, the consumers, the ideal is a bill which establishes consumers as a majority on every board, committee, or agency that has a policymaking, planning, and evaluating role, and this at every level of operation.

I would like to add the following. As Sister Margaret Farley pointed out, please note that remarkable consistency exists in the statement of our fellow panelists and supporting organizations. That consistency must surely make an impact.

Second, Dr. Spencer has provided all of us with the result of research and study. I am always comforted to find research and study supporting the common sense of the street.

Dr. Milton Roemer's cited article, "Penny-Wise and Pound-Foolish," because of the deterrent to every early diagnosis, that excess cost to the State was $1.23 million, I am very proud to claim that if you had come down to the poor of Chicago, which is West Side, you would have gotten the same message and it would not have taken anywhere near the time that the research that Dr. Spencer quotes took.

There is a wisdom in the street that is both reliable and irreplaceable.

Thank you again for this opportunity to share my experience and convictions.

[The material appended to the statement of the Interreligious Coalition on Health Care follows:]

BIOGRAPHICAL SKETCH OF S. MARGARET FARLEY, R.S.M.

Margaret Farley is presently an Associate Professor of Ethics at Yale Divinity School. Her special interest and current research topics cover a wide range: medical ethics, new roles for women in ministry, ethics of commitment, history of theological ethics, ethics and sexuality, and the relation between ethics and spirituality.

She received an A.B. and a M.A. in philosophy from the University of Detroit, and a M. Phil. and Ph.D. in Religious Studies from Yale University.

Her memberships include Board of Directors of the Network (a registered religious lobby for social justice in Washington, D.C.), the Executive Board of the American Academy of Religion, the Society for Religion in Higher Education, the Catholic Theological Society of America, and the Advisory Board of the Pastoral Care Center at St. Raphael's Hospital, New Haven, Connecticut. She is Associate Editor of the *JRE Studies in Religious Ethics.*

She has taught philosophy at the Mercy College of Detroit and the University of Detroit as a guest lecturer. She held a Danforth Teacher Grant for 1967–1969 and a Kent Fellowship from 1969–1971. Since 1971, she has taught at Yale Divinity School. Her many publications demonstrate a deep concern pertaining to issues of medical care, women's rights, sexuality and ethics.

BIOGRAPHICAL SKETCH OF DR. MALCOLM LEE PETERSON

Dr. Malcolm Lee Peterson graduated from Stanford University, received his M.D. at the University of Washington and a Ph. D. in Biochemistry from the Rockefeller Institute.

His professional experience extends from working as a laboratory technician in California and an internship at Philadelphia General Hospital to Assistant Resident in Medicine at Barnes Hospital in St. Louis; Assistant Physician to the Hospital of the Rockefeller Institute and Director of the Gastroenterology Division; and Assistant Professor of Medicine of the Department of Medicine, Washington University School of Medicine, St. Louis, Mo. Internationally, he was a visiting fellow of the Department of Gastroenterology of the Central Middlesex Hospital, London, England; Visiting Professor of Medicine, and consultant to Beni Messous Hospital, Algeria, and the Cuban Ministry of Public Health of the Pan American Health Organization.

Most recently he is serving as Associate Professor of Medicine, School of Health Services, and Dean of the School of Health Services, Johns Hopkins School of Medicine.

Dr. Peterson is considered a national and international authority on health delivery systems. He has served on the Task Force on Health Care of the Friends Committee on National Legislation and the American Friends Service Committee.

BIOGRAPHICAL SKETCH OF DR. C. DAVID SPENCER

Dr. C. David Spencer is a board-certified internist who spent the past four years as Medical Director of an HEW-funded community health center in eastern Washington State established primarily for migrant and seasonal farm workers. During that time he was also Clinical Assistant Professor in the School of Public Health & Community Medicine of the University of Washington. He worked closely with the Medex physician assistant program of the University of Washington and as a consultant to the Medex program of the University of Hawaii.

Dr. Spencer received his M.D. from the University of Pennsylvania in 1962 and a Ph. D. in biochemistry in 1965. Following internship at the New York Hospital-Cornell Medical Center in 1965–66, he spent two years in the U.S. Public Health Service as physician with the Peace Corps in Micronesia. From 1968 to 1971 he had his residency in internal medicine and fellowship in infectious diseases at the University of Washington in Seattle.

He is presently Director of Health Services at the Kensington Georgetown Medical Center, one of three clinics comprising the Georgetown University Community Health Plan, and is Clinical Assistant Professor of the Department of Community Medicine of Georgetown University Medical School.

BIOGRAPHICAL SKETCH OF DR. ANNETTE MARY LYNCH

Dr. Annette Mary Lynch is a naturalized American citizen who was born and received her initial medical training in Australia. In addition to her training in medicine at the University of Sydney and her internship at St. George Hospital, Kogarah, N.S.W., Australia, she has also had a fellowship in Gastroenterology at the University of Pennsylvania and received a diploma in Public Health from the University of Bristol in England.

Her publications and lectureships indicate a broad interest in health services in the community. She has served in a variety of posts: a founding member of the Philadelphia Nutrition Council, member of the Advisory Task Force on Child Abuse of the Pennsylvania Department of Public Welfare; membership in the Friends Committee on National Legislation/American Friends Service Committee Health Task Force; and advisor to the Texas Health Consumer Participation Project.

Her work as a practicing physician has been primarily with low-income people in Sydney, Australia; as locum tenens in Chesterfield, Derbyshire, England; Beeston, Nottinghamshire, England; and Raleigh, Essex, England.

In the United States she has served as Assistant Professor of Epidemiology, Womens Medical College of Pennsylvania; Associate Professor of Community Medicine, Hahnemann Medical College and Hospital; Associate Director, Division of School Health Services, the School District of Philadelphia; and Field Supervisor to Temple University School of Social Administration and State University of Pennsylvania, College of Human Development.

She is presently the Director of the School Health Program, Bureau of Children's Preventive and Restorative Services of the Commonwealth of Pennsylvania.

BIOGRAPHICAL SKETCH OF RICHARD J. EHRENS

Richard J. Ehrens received a B.A., S.T.B. and S.T.L. from the St. Mary of the Lake Seminary, and he was also ordained as a Roman Catholic priest there. He received a M.A. in Classics from Notre Dame University.

He has had wide experience as a pastor, teacher and organizer. From 1959 to 1962, he was the Associate Pastor of the St. James Church and organized the Young Christian Student Association and the Young Christian Workers Group. From 1962 to 1966, he was an instructor at the Quigley Preparatory Seminary, and from 1966 to 1970, assistant principal at the same seminary.

He has a vast record of community and civic involvement. He is the Chairman of the Board of Directors of the Miles Square Health Center. He has been a chaplain at Michael Reese and Mary Thompson Hospitals, and a lecturer on consumer affairs at the National Association of Health Centers Convention. In the past five years, he has initiated a food coop, a food pantry and clothing center, and a community center, developed a trades skills program and a summer employment program for teenagers, chaired the Advisory Council for Local Legal Aid Services and also an organization called Blacks Organized for Stability and Security.

He has participated in the Arbitration Team of the Archdiocesan Catholic School Board, the Pastoral Resource Committee, the Miles Square Federation By-Laws Committee, and the Board of Directors of the Sojourner Truth Home for Wayward Girls. His memberships include the Mid-West and National Associations of Neighborhood Health Centers, the West Side Chicago Health Planning Organization, the Chicago Urban League, and the National Catholic Council for Interracial Justice.

He is presently administrator and pastor of the St. Malachy Church and School.

APPENDIX

Organizations and constituent bodies officially supporting this testimony

Group	*Membership*
1. Friends Committee on National Legislation	200
2. United Methodist Church—Board of Church and Society	90
3. Church of the Brethren	183, 000
4. United Presbyterian Church, USA	3, 000, 000
5. Union of American Hebrew Congregations (700 congregations)	1, 000, 000
6. Network	3, 000
7. United Church of Christ Center for Social Action	1, 800, 000
8. Christian Church (Disciples of Christ) Dept. of Church in Society	1, 200, 000
9. Jesuit Conference	6, 000

Total support—nine groups—over 7,000,000 constituents.

PRINCIPLES OF HEALTH CARE IN THE UNITED STATES OF AMERICA

As Friends labor around the world to alleviate human suffering and to ensure that human beings are accepted for their personal worth, free from any discrimination, we find ourselves faced with inequities in both the manner in which people of our own country receive health care and in the opportunities to participate in the health care field as either consumers or providers of health services.

Urgently needed is the development of a rationally designed, integrated, comprehensive and responsible system for providing to all residents an adequate level of quality health care.

There are many people who cannot find or afford needed health care in the United States of America today. In the face of what is possible, it is nothing short of immoral that we do not have a health care system that can meet these needs. The Friends Committee on National Legislation proposes, therefore, the following principles for a nationally coordinated Health Care System.

GLOSSARY OF TERMS

Comprehensive health care includes all types of health services now practiced or provided, but not limited to them.

Health consumers or users are the general public, including those described as providers.

Health providers include all health practitioners (physicians, nurses, nurse practitioners, technicians, nutritionists and others), hospital, clinic and nursing home proprietors and administrators, insurers, drug producers or dispensers.

Health maintenance organizations are medical organizations offering comprehensive health services at a fixed monthly or annual price—the principal alternative to traditional fee-for-service medical practice.

PRINCIPLES

1. The establishment of a nationally coordinated health care system

A nationally coordinated, socially responsible, publicly accountable, comprehensive health care system should be established for the promotion of health, the prevention of disease, the diagnosis and treatment of injury, disease or illness, and rehabilitation.

2. Positive health concept

The system should begin with a concept of positive health which seeks the well-being of the whole person, emphasizing the development and maintenance of good health through consumer education, preventive health care and community health action programs. We recognize that each human being is both an individual with personal potential, problems, and responsibilities, and at the same time a part of a total social and physical environment.

3. Good health care for each person

The system of health care must assure good health care to all residents nationwide without any discrimination on the basis of sex, race or the ability to pay.

4. Consumer participation

The system should be truly responsive to the real and felt need of the consumers of health services. Responsiveness grows from substantial direct consumer participation in the responsibility for decisions affecting the priorities in local health care delivery, the proportions among the different kinds of health personnel, the location, operation, and facilities of health care delivery, the location and operation of health personnel training, and the methods of financing, controlling, and evaluating all aspects of the services. Health providers (professional and other) should likewise participate actively. The system should encourage personal and community initiative and responsibility.

5. Individual responsibility

All consumers of health care should be educated and encouraged to: Take responsibility to inform themselves on the basics of maintaining their health conscientiously follow these basics so as to enjoy good health; join a local health services unit of their choice to secure regular assessment of their health condition; use the health unit services to meet illnesses, injuries and disabilities; take their share of responsibility as good members of the unit; and cooperate intelligently with health providers of their choice.

6. Freedom of choice

Options as to type and method of medical care, such as osteopathy, homeopathy, etc., should continue. There can be no coercion to participate in any particular system, either of consumers or providers. Doctors and other professionals should be free to engage in private practice and consumers to patronize them. A rational design would include continuity of care for the consumer by the health provider of his choice.

7. New approaches

Within these principles new approaches to research, delivery, training, access, payment, financing, and all other aspects of the health field should be carefully explored, tried out and evaluated. New approaches should be evaluated particularly as to sensitivity to human need, rationale of organization, and cost effectiveness. Special attention should be given to problems of the aging and those in terminal illness.

8. Health assessment and maintenance

Every individual and family should be encouraged to enroll in a local health unit and thus establish an ongoing relationship with a team of local health providers. Within the limits of the team's and unit's resources, these consumers should have access to regular health assessment with continuity in their health care. Special health problems may require referral to appropriate specialists or facilities including paramedical in or beyond the local area.

Individuals or families moving to another location should be encouraged to transfer as quickly as possible to a health unit in the new location and provision should be made for prompt transfer of their health record.

9. Local health and service delivery

The largest field for innovation is the delivery of health care in local units. Groups should be encouraged to create and improve health facilities, choosing among different patterns of health care delivery. Such diversity will help prevent the undesirable aspects of bureaucracy.

Local health units, both urban and rural, should be arranged so that consumers can obtain health and medical services promptly and have a choice among local units.

Each unit also should have responsibility for collecting and disseminating accurate information concerning local health needs and services as a part of a nationwide reporting system. This information should be used to guide health care delivery programs, public education programs, manpower training programs, and location and type of facilities.

10. Regional facilities

Regionally, within the United States, existing programs and facilities should be coordinated and new programs developed to meet specialized health needs, conduct research, and recruit, train, and develop personnel.

11. Federal participation at the national level

Everyone must have prompt access to good health care and the federal government must carry the legal responsibility to see to it that such provision is made. The Health Care System on the national level should provide only those direct services which cannot be supplied feasibly on any other level of the health care system.

Primarily, it should be responsible for the encouragement and coordination of research, the establishment and enforcement of minimal standards of health care, regulations for health services, guidelines for the management and accountability to the general public and the assimilation and distribution of health information gathered throughout the health care system. These standards and guidelines should be established with the participation of regional and local councils. The national council should include some representatives from each regional council, some of whom should be consumer participants. In order to achieve sensitivity to all points of view all national, reigonal and local councils should be encouraged to make decisions on the basis of consensus. Coordination is achieved in part by participation in planning and by open availability of information. The national council should have access to health-related information developed by governmental organizations.

The diversity of local units although having great advantages, has some drawbacks. Some people may not have adequate choice of units. Quite a few may be left out. These are apt to be the temporarily employed, unemployed, widowed, dependents, migrant workers, retired persons, etc. They may lack eligibility or group membership or the funds for payment. In all such cases suitable arrangements must be made with an existing private or public facility.

There may at any time be quite a few health delivery facilities which do not live up to the minimal standards for health care. The framework of law must provide for creative ways to bring these units up to par.

12. Health personnel development and deployment

The complete range of health providers should be included in any such system. The system should be open to new and alternative modes of beneficial therapy and seek to produce and provide the proper balance of doctors, dentists, and other skilled providers of health services based on the health needs of the country. Also, there must be a commitment to place the persons in jobs where they are needed, and if possible for which they are most adequately prepared. The system should provide for a wide variety of health careers with open access through education and training. Especial consideration must be given to removing discriminatory restrictions of an economic or professional nature which deny to many of our society the opportunity to train for health professions. New roles in the field of primary health care delivery should be developed which would provide quality health services while permitting health professionals to use their skills in an optimal way.

The system should provide the means whereby health providers of all levels of experience will serve in areas of greatest health need, such as ghettos or rural areas with insufficient personnel. Patients, with their consent, should expect some of their care to come from health providers in training.

13. Health information

We believe that a health problem is anything which adversely affects the physical or mental health of an individual or community. The system, therefore, should have the right and the responsibility to bring to public attention the practices and programs—public and private—which have an adverse effect on national or local health. Consumers need maximum information about family planning, health, accidents, disease and disability. People also need to develop appropriate skills to promote their own health, care for disease and disability, and utilize health services properly. Special attention should be given local needs, including environmental health concerns, and education on health problems.

14. Efficiency of the system

The most equitable and efficient use of our nation's limited health resources should be sought through comprehensive information, assessment, cost effective analysis, research, and planning for the future. The audit and review process should come from both within and without the system, through methods including both consumer and peer review. The system should be designed to minimize misuse.

Insurers may offer some savings in cost by provision of accounting systems for many types of health services. Cost effectiveness should be the criterion for their use.

15. Financing health care

The mixture of public and private facilities requires several forms of financing:

a. Cooperatives, group practice facilities and other forms of Health Maintenance Organizations may well be financed by prepayment plans. Part or all of such payments may be made by the federal government, especially for those unable to do this themselves. The federal government should also help to organize and capitalize such group practice facilities where appropriate. Employer-employee plans can be financed by scheduled contributions.

b. Exemptions or reimbursement should not be made to local units or portions thereof not meeting federal standards. Facilities falling below minimal standards might, however, receive some federal funding or exemption when steps have been undertaken to meet these standards progressively and fully within a reasonable time.

c. Where federal funding or tax exemption is not sought, organizations or individuals may provide health services unless and until evidence of harm to patients or others can be proved.

d. Any necessary services or training provided by the federal government whether at the local, regional or national level, should be financed either out of general revenue or by a special progressive tax, or a combination of both that contains no special exemptions. These funds should be in the form of a permanent trust rather than a one or multiple-year authority. Effective cost control and consideration of national priorities are fundamental parts of a comprehensive health system.

16. Cooperation on health matters with other countries

The health system should arrange mutual exchange of health information and mutual assistance with other nations through the United Nations and its specialized agencies. Health and disease know no national boundaries.

> We believe with John Woolman that to "labor for the perfect redemption from the spirit of oppression is the great business of the whole family of Christ Jesus in this world."
>
> As Friends we must remind ourselves that "the sick and those caring for them have need of our prayers. But let us not imagine . . . that a few sentimental good wishes from a distance are all that is needed. Whenever we intercede in prayer we must be prepared for an answer which places a practical obligation upon us. A prayer is always a commitment."—THOMAS F. GREEN, 1952

In an attitude of caring we feel that these several principles should enlighten any rationally designed, socially responsible health care program.

NETWORK POLICY STATEMENT ON HEALTH

NETWORK supports the organization of a health care system based on the principle that health care is a right for all persons. Basic coverage should be universal and stress preventive medical services, episodic and catastrophic illness care. The development of national planning and cost control should be provided by trust fund financing and advance budgeting, eliminating the need for out-of-pocket payment at the time of delivery of services. Public control of our basic health policies and full public accountability mechanisms should be developed which ensure consumer participation.

The NETWORK Policy Statement on Health contains five principles:

1. Good health care is a fundamental right of every citizen. Pope John XXIII in Pacem in Terris stated: "Beginning our discussion of the right of man, we see that every man has the right to life, to bodily integrity, and to the means which are suitable for the proper development of life; these are primarily food, clothing, shelter, rest, medical care, and finally the necessary social services."

2. Access to basic health care should be available to all citizens on an equal basis, regardless of race, sex, religion, national origin or ability to pay.

3. The health delivery system should be based on a preventive health concept and should have comprehensive coverage, including physical, dental, psychiatric, and long-term care.

4. The health delivery system should provide effective incentives for quality of care and controls on costs.

5. Consumers should be represented on every level of policymaking connected with the planning and administration of the national health care delivery system.

Approved January 12, 1973.

RESOLUTION ON NATIONAL HEALTH CARE POLICY

(Voted by the 10th General Synod, United Church of Christ)

Whereas public dissatisfaction and frustration with the American Health Care System continues to rise and the increasing health needs of many Americans are unmet; and

Whereas Congress, in its response to the recognized need for change in the present American Health System, is considering the enactment of some form of National Health Care Insurance in the future; and

Whereas the Church, recognizing that its responsibility for health and well-being of people extends far beyond its own resources, must address itself to total health care system of the nation and to those national policies which affect the health and health care of people; and

Whereas the efforts of the Church in its advocacy for effective efficient quality care for all persons would be greatly enhanced by the 10th General Synod's affirmation of standards against which any proposals for improvement in the health care system should be measured.

Whereas the Illinois, Ohio and other Conferences of the United Church of Christ have called upon the 10th General Synod to take affirmative action on national health care concerns; therefore be it

Resolved That the 10th General Synod affirm the attached Statement of Policy on National Health Care, adopted by the United Church Board for Homeland Ministries on October 20, 1971; recommend its adequate dissemination and implementation through efforts at the National, Conference, Association and local church levels; and recommend that a report of these efforts be presented by the United Church Board for Homeland Ministries to the Eleventh General Synod.

STATEMENT OF POLICY ON NATIONAL HEALTH CARE

(Voted by the United Church Board for Homeland Ministries, October 20, 1971, in St. Petersburg, Florida)

1. Throughout its history, the church has witnessed to its calling of healing and making whole. The United Church of Christ has provided many direct health care services in the past and continues to affirm its commitment to health care through church-related hospitals, homes for the aged, nursing homes, and other health care programs. At the same time, the church recognizes that its responsibility for the health and well-being of people extends far beyond its own direct resources. Therefore, the health ministry of the church must address itself to the total health care system of the nation and to those national policies which affect the health and health care of people.

2. The foundation of a national health policy for the United States should rest on the well-known philosophy of the World Health Organization. "Enjoyment of the highest attainable standards of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, or economic and social conditions."

3. The Federal Government of the United States, as the instrument of all the people, "to promote the general welfare," has the ultimate responsibility to guarantee the fulfillment of this right, including adequate financing, planning, setting and enforcing of standards, and assuring equal access for all persons to health care resources. The private health care sectors have a responsibility to cooperate with each other and with the government in fulfilling this right. The church, along with other organizations, has a responsibility to act as advocate for effective, efficient quality health care for all persons. The church has a particular responsibility to be an advocate for persons and groups who are

currently receiving inadequate health care and/or who are inadequately represented in the making of health care policy decisions.

4. Standards against which the effectiveness of the health care system and of proposals for improvement in the health care system should be measured, include the following:

A. HEALTH CARE

1. Care should be universal. The objective should be that each and every person receive health care as a right.

2. Care should be accessible. Equal access to needed health services should be assured, without restrictions based on amount or source of personal or family income; on rural, urban, or suburban place of residence; on citizenship or on length of residency in the community; or on ability to pay for them.

3. Care should be comprehensive. It should include elements which:

(*a*) Build health—such as nutrition, physical fitness, and environmental health programs.

(*b*) Prevent illness and disability such as immunization, sanitation, epidemiology, and similar services.

(*c*) Provide for early diagnosis and treatment—such as regular physical examinations, well baby clinics, education of consumers and providers of service to be alert to early symptoms of disease, and other programs designed to accomplish this objective.

(*d*) Provide treatment resources for more serious malfunctions and diseases as well as for those which are more common—such as general hospitals, mental hospitals, extended care facilities, outpatient treatment, nursing and intermediate care for chronically ill, and home health care.

(*e*) Serve to rehabilitate persons for optimum individual and social functioning.

(*f*) Provide mental health services—in-patient, out-patient, preventive and rehabilitative.

(*g*) Provide dental care-preventive and remedial.

(*h*) In order to improve methods of prevention, diagnosis and treatment, provide for adequate research.

(*i*) To assure that needed services can be made available, provide for education and training of health care personnel, professional and para-professional.

4. There should be continuity of care. No jurisdictional or administrative barriers should prevent a patient from moving from one type of service to another on the basis of need and optimum opportunity for restoration to health.

B. THE FINANCING OF HEALTH SERVICES

In 1970 expenditures of nearly $70 Billion from public and private sources of health care, did not provide services which came close to attaining the above stated goals. Funds available for health care are not unlimited. Therefore, it is imperative that what is expended enhance achievement of an effective health service delivery system.

Methods of financing must assure equal access to health services, without stigma or restriction; e.g., for the poor, the near poor, the middle income group, as well as the affluent; for self-employed, unemployed, and non-unionized employed persons as well as for employees of corporations covered by collective bargaining contracts; for aged, middle aged and young. The burden of paying for health care should vary in proportion to ability to pay. The method of financing should encourage (and not discourage) persons to seek preventive health care, early diagnosis, and early treatment rather than postponing such action until a crisis occurs.

Providers of health care must be assured full payment for reasonable costs including adequate compensation for all workers in health programs, professional, para-professional, and non-professional. Structures and procedures for quality and cost control required to protect the public interest must be an integral part of the health care system.

The financing mechanism must be such as to be a lever which permits and fosters modification in the organization and delivery of service, rewarding that which helps to attain the goals stated above in an efficient and effective manner, and penalizing developments and organizations which do not.

C. ORGANIZATION OF HEALTH SERVICES

The achievement of better access, effectiveness, and efficiency in the maintenance of health and the delivery of health services requires improved planning and organization of services to assure complete geographical coverage, and a structured interrelation of preventive service, primary care, specialized care, and other dimensions of health care.

On the other hand, within national standards, there must be sufficient flexibility to permit adaptation to local health needs, wishes, and cultural patterns and to permit innovation in both the organization and the delivery of health care. This includes the flexibility to permit a variety of public and private auspices and mixes in the administration of health care in a given area. Special efforts should be made to preserve and enhance the elements of volunteerism and religious and humanitarian motivation to service which have characterized many sectors of the present health care system.

Regardless of public or private auspice, the planning and administration of health care at all levels must involve consumers as full partners in decision making with health professionals and administrators.

Statement by Geraldine Zigler Glick on Behalf of the Church of the Brethren General Board on National Health Insurance

My name is Geraldine Zigler Glick, Post Office Box 397, Broadway, Virginia I am a homemaker and a member of the General Board of the Church of the Brethren. I am presenting this paper on behalf of the General Board, the administrative body of the denomination, located in Elgin, Illinois.

The General Board adopted a statement on Health Care in 1973 at its meeting in Fresno, California. This statement called on the members of the Church of the Brethren to work for legislation which will deliver adequate health care to all people.

The Church of the Brethren is urging Congress to pass legislation which will give to the total population of our vast country the quality health care they deserve. Quality health care is the right of each individual regardless of race, creed, color, or income, and the responsibility of the government to provide. Legislation should be comprehensive so that it will meet the needs of the total person. It should have few restrictions and be totally reliable so that people know to what they are entitled. It should be a bill which reaches and touches the total person from conception to death.

The pregnant woman who is carrying a potential citizen has the right to good nutrition and health care for the birth of a healthy, well formed child. We know that if that person has quality prenatal care the new-born has the bonus of a healthy beginning. Among the developed countries, the United States ranks nineteen in infant mortality (*1973 Demographic Yearbook of the United Nations*). Too many babies die in the United States during the first year of life. This need not be so. Our doctors are among the most competent and skilled in the world and our medical resources, research and technology are first rate. It is when we neglect the responsibility of providing the quality care necessary for healthy children that we end up with children who will have a future of dullness and limited productivity.

Through the first years of life it is important that a child be given the right food to eat, proper immunizations, vaccinations and oral health care. A child who lacks good nutrition often matures into a person who is dependent on society because of some kind of mental or physical illness or deficiency. A child with a mouth full of bad teeth has a future of painful, expensive treatment. A child with aching limbs due to poor nutrition faces a lifetime of crippling problems. Constant pain or dullness limits the potential of an individual. It has been found that correct nutrition and good health care has much influence in producing healthy, productive human beings.

National Health Insurance reaches into many facets of our living. Not only does it involve payment for diagnostic and curative services, but it should also cover those preventive activities which make and keep a person healthy in the first place. For example, a truly comprehensive program of national health insurance should include a new and innovative plan of nutrition education which would prevent many of the health problems in this country, a plan which could be implemented in day care centers, schools, and homes, using all available media. This education should replace the many ads for junk foods which, in the long run, are detrimental to our health. Educating children and parents in this way would be a simple and direct way of showing that we are serious about the idea of creating a healthy nation.

As our citizens grow older they should have the peace of mind of knowing that they will be well taken care of when illness strikes. Astronomical hospital and doctor costs should not wipe out a life time of savings. Illness and loss of work time often keeps families on the edge of poverty. Our nation should feel the responsibility to provide the best of care for its citizens from the time they are born through childhood, adulthood, retirement and old age.

At the Annual Conference of the Church of the Brethren on June 26, 1974, delegates from across this nation unanimously adopted a statement on national health insurance which included the following sentence: "We feel that it would be an unconscionable breach of trust for the Congress to adopt a plan which would drastically increase the cost of health care delivery, to create windfall profits for insurance companies, to continue a program of health services which deprives the persons who have least access to good medical care, or to promise medical care services without staging the implementation of this transition." There are many bills before you with many different solutions. To bring all these ideas together and form an equitable bill will be a job of great magnitude. But we feel that the issue is of such great importance that we urge you and your staff to take time to deliberate and form the most comprehensive bill possible. We are convinced that the American people will support you in your effort.

As adopted in June, 1973, the General Board of the Church of the Brethen urges the Congress to enact legislation which would:

"1. Assure every person, regardless of wealth, social status, or any other condition, access to the best available, comprehensive health care (including physical, dental, and mental care) with emphasis placed upon prevention as well as treatment and rehabilitation;

"2. Establish national standards for delivery and licensure with policy making carried out at regional, state, area and community levels;

"3. Assure that consumers be represented on boards of professionals and public officials to design and administer every level of the national health care delivery system;

"4. Provide financial support for new medical, psychological, dental and nursing schools in order to increase the number of health personnel;

"5. Make provision for increased training and use of paramedical personnel; and

"6. Assure the rights of persons to choose among doctors and facilities for medical care, as well as to assure that doctors and other health personnel not be hindered from choosing the type of medical practice in which they wish to engage."

We would suggest that the committee give serious thought to the following when working on these bills:

1. That everyone living in the United States would be eligible for the benefits.
2. That the program would pay for almost all personal health care services including catastrophic coverage. Hopefully, it would include dental care for children.
3. That financing would be based on a special tax on the employer, employee and self-employed with matching funds from the federal government. (118 billion dollars is spent now on partial and inadequate health care.)
4. That physicians, dentists, hospitals, and other health care providers would be paid directly from the above fund.
5. That programs which are already in existence such as Medicare, Medicaid, Champus, Workmen's Compensation and many other programs would be covered in this comprehensive plan.

In conclusion, we encourage you to write the most comprehensive bill which will give the citizens of this nation an answer to their plea for adequate health care. It is obvious that the federal government must be the administrator of such services, but allowing the treatment and care to be determined by the provider. The issue has been before you for several years and many plans and suggestions have come before you, but the basic right for quality health care is the primary premise that we make. That means quality health care for all people from conception to death. As a religious body we are keenly interested in the quality of life for each individual and would urge each one of you to couch your decisions in the fact that each individual is unique and special in their own right. This would be one of the most far reaching and important pieces of legislation ever passed if the total population benefits from it.

POLICY STATEMENT ON HEALTH CARE CONCERNS ADOPTED BY THE GENERAL BOARD, NATIONAL COUNCIL OF THE CHURCHES OF CHRIST IN THE U.S.A., SEPTEMBER 10, 1971

Health and holy are words with a common origin akin to whole, sound, hale and well. Their close relationship in Christian history stems from the life and work of Jesus Christ "who went about all Galilee teaching in their synagogues, preaching the gospel of the Kingdom and healing every disease and infirmity among the people."

Through the centuries Christians have been constrained to show forth the love of God not only by preaching but also by healing. Society has frequently been alerted by the churches to meet health needs. Churches have nurtured a large proportion of persons engaged in health professions. Extensive health services have been developed and maintained by churches in this nation and abroad. Through all their activities in the field of health, churches have aided men more fully to render service to God and their fellows and have expressed the Christian faith in love.

The major portion of the health care system, however, is not now administered or financed by church-related institutions. Therefore, the churches' concern for health for all people must express itself in efforts to see that communities, states and the nation provide cooperatively, through governmental and non-governmental programs, an effective system of health care. In matters of health the rights and well-being of one group in society cannot be secured without securing them for all.

Church-related health services should be a responsible part of the total health care system, working in collaboration with governmental as well as other voluntary health agencies.

The General Board of the National Council of the Churches of Christ in the United States of America endorses the development of a health care system which is characterized as follows:

The foundation of a national health policy for the United States should rest on the well-known philosopry of the World Health Organization:

Enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief or economic and social conditions.

STANDARDS

Standards against which the effectiveness of the health care system should be measured include the following:

A. Health care

(1) Quality care should be universal. The objective should be that each and every person receive sufficient and quality health care *as a right*.

(2) Quality care should be accessible. Needed is continual access to basic medical care; daily access to routine health guidance; immediate access to emergency service; periodic access to diagnostic and screening procedures. Equal access to needed health services should be assured, without restrictions based on amount or source of personal or family income; on rural, urban, or suburban place of residence; on citizenship or on length of residency in the community; or on the ability to pay for them.

(3) Care should be comprehensive. It should include elements which:

(a) Build health—such as nutrition, physical fitness, and environmental health programs and housing.

(b) Prevent illness and disability—inoculations, sanitation, epidemiology, and similar services.

(c) Provide for early diagnosis and treatment—regular physical examinations, education of consumers and providers of service to be alert to early symptoms of disease, and other programs designed to accomplish this objective.

(d) Provide treatment resources for more serious malfunctions and diseases as well as for those which are more common—including hospitals, extended care facilities, out-patient treatment, nursing and intermediate care for chronically ill and home health care

(e) Serve to rehabilitate persons for optimum individual and social functioning, including, but not limited to, ability to be usefully and gainfully employed.

(f) Provide mental health services—in-patient, out-patient, preventive and rehabilitative.

(g) Provide dental care—preventive and remedial.

(h) Provide for adequate research to improve methods of preventive diagnosis and treatment.

(i) Provide for a massive increase in education and training of health care personnel, professional and para-professional, with special emphasis on recruitment of members of Black and other minority groups, to assure that needed services can be made available.

(4) There should be continuity of care. No jurisdictional or administrative barriers should prevent a patient from moving from one type of service to another on the basis of need and optimum opportunity for restoration to health or for long-term care.

B. The financing of health services

Current annual expenditures of nearly $70 billion from public and private sources for health care are not providing services which come close to meeting the standards described. Funds available for health care are not unlimited. Therefore, it is imperative that what is expended enhance achievement of an effective health services delivery system.

Methods of financing must assure equal access to quality health services, without stigma or restriction, for the poor, the near poor, the middle income group, as well as the affluent; for self-employed and un-employed persons as well as for employees of corporations covered by collective bargaining contracts. The burden of paying for health care should vary in proportion to ability to pay. The method of financing should encourage persons to seek health care rather than postponing such action until a crisis occurs. Deductibles, co-insurance, and other features which require the consumer to pay a fee for each service may hinder early detection and treatment of physical disabilities and should not be utilized to exclude benefits.

Providers of health care should be assured payment for reasonable costs including adequate compensation for all workers in health programs, professional, para-professional, and non-professional. Procedures for controlling quality and cost of health care required to protect the public interest must be an integral part of the health care system.

C. Consumer participation

The health care system must be responsive to regional and local needs and variation and to the needs and cultural patterns of individual consumers. This calls for methods of planning and administering services which involve consumers (non-providers of health services) as full participants in decision-making. Health professionals should make individual decisions affecting the health of their patients while the public should become the ultimate determinant of the health care system and how services are delivered, paid for and organized. Consumer representatives should be selected in such a way that they are responsible to organizations concerned with public interest in health care. There should be sufficient flexibility within the national system to permit a significant measure of local self-determination, within the limits of necessary fiscal and quality standards.

SUMMARY

The General Board of the National Council of Churches of Christ in the U.S.A. endorses the development of a national health system which will assure quality health care as a right to all persons in an accessible, effective and efficient manner, with a method of funding which makes this possible. It calls upon units of the Council to support the achievement of this goal in appropriate ways.

It calls the attention of member communions to the urgency of need for change in the health care delivery system in the United States. It reminds them of special opportunities and challenges which face church-related health agencies, such as to demonstrate innovative community health services and methods of consumer involvement in decision-making, and to interpret health needs and problems to the constituencies of sponsoring religious bodies.

THE NEED FOR A NEW HEALTH CARE POLICY IN THE UNITED STATES

A Statement of the
Interreligious Task Force on Health Care

Representatives of:
Jewish
Roman Catholic
and Protestant
organizations

September, 1972

FOREWORD

In June 1971 a group of staff people responsible for services and social action in the area of health and welfare from several religious groups was convened by the National Council of Churches to discuss mutual concerns about health care in the United States.

At that time each organization was at some stage in the process of developing or implementing a policy statement on health care in the United States. Religious organizations are concerned about the wholeness of persons as children of God and therefore about their physical and mental health. For this reason the emergence of health care as an urgent national concern confronted religious groups with an imperative to care and to act.

Without losing sight of the crucial importance of human problems affecting health—such as pollution, hunger, poverty, and war, and of ethical issues arising out of new biomedical technology—this statement will be directed to the provision of personal health care. This choice is made because of the imminence of federal legislation dealing with this subject.

Our regular meeting served to keep us informed about the content and process of policy development in our respective organizations and steps being taken to implement policies.

In order to test the extent of agreement among us, Edward Krill of the U.S. Catholic Conference very generously agreed to formulate a composite statement based on positions already adopted by our organizations. While we expected general agreement on the nature and extent of the problem, we were encouraged to find that there was also substantial agreement on the goals toward which efforts at solution should be directed.

It seemed feasible, therefore, to attempt to prepare a document which would represent the best judgment of members of the Task Force. While this document draws heavily on policy statements of several organizations, it does not speak for our respective organizations. Rather, its purpose is to speak *to* members of our organizations, particularly to those who influence decision-making in churches, synagogues, health and welfare agencies, and in communities. Members of the Task Force are committed generally to the point of view expressed here and we believe that it is consistent with policies of religious organizations which have adopted policy positions on health care.

A RELIGIOUS PERSPECTIVE

Our vision, illuminated by the Judeo-Christian understanding of history, sees that God's holy purpose is for mankind to be of worth and to be well, to be healthy and to nurture health for one another. The vision of faith sees the present reality in the light of what might be. Pain that is unavoidable can be accepted but ill-health that we have the knowledge and resources to avoid is intolerable. We acknowledge a commitment under God, to exercise public compassion and justice for all people of our land and to increase the well-being of all.

The pivotal issue, underlying discussions of all proposals for national health programs, deals with an emerging social philosophy regarding health care. This philosophy affirms that the availability of good health care is a right, to be enjoyed by all citizens—rather than a privilege to be limited by considerations of race, religion, political belief, or economic or social conditions. Therefore, our goal is that each person receive sufficient health care of good quality as a right and as a recognition of the dignity of man.

In an affluent society the provision of adequate health care is feasible. Therefore, unimpeded access to it should be a legal right of all citizens, a corollary to the right to life itself. The responsibility for fulfilling this right rests with both the individual and society.

We recognize that we are each involved in self-health care, in mutual health care in our primary social groups and in supporting health care services at home and abroad. What happens to our neighbors' health happens to us. An epidemic knows no political or economic or social boundaries. Residents of Keokuk or Chicago suffer ravages of Hong Kong flu just as residents of Asian cities and hamlets.

The development and preservation of good health requires a national commitment with well defined purposes and explicit goals. We believe that health care in the United States, though now substantially an endeavor of private and independent sectors, cannot be left to private resources and private initiatives alone. We believe the general public has direct responsibilities for designing and developing a comprehensive, publicly-oriented national health policy, which will make real the rights of individuals and the responsibilities of society.

The development of a comprehensive, morally defensible health care policy in the United States is not solely the responsibility of health care providers, whose knowledge and skill and art make superior health care possible for many. Our whole society gives priority to the production and consumption of goods, to profit-making and the defense of wealth, neglecting basic human needs. Therefore, all members of this society share responsibility for determining what objectives and priorities should be in health care.

Health Care Crisis

President Nixon, in July of 1969, said, "We face a massive crisis in this area (of health care) and unless action is taken, both administratively and legislatively, to meet that crisis . . . we will have a breakdown in our medical care system which could have consequences affecting millions of people throughout this country."

In 1971 the report of the Citizens Board of Inquiry into Health Services for Americans stated (inter alia):

"Americans are angry and frustrated about health services. . . . The anger is intense. It springs from frustration with efforts to obtain health services from doctors, hospitals, health departments and a host of programs and agencies that are involved with the delivery of health care. Anger also comes from exasperation that conspicuous deficiencies are met by a succession of studies and, at best, ineffectual efforts at reform. Let there be no mistake. The anger is well-founded. The deficiencies are real."[1]

Dr. Herman E. Hilleboe, in the 11th Bronfman Lecture to the American Public Health Association attributes to the late Walter Reuther speaking in 1968 the following: ". . . thirty million Americans live in poverty even though we have a Gross National Product of one thousand billion dollars. Let's face it; the poor are shut out of affluent society. Few other aspects of American life than health display a greater gap between promise and performance—reason enough for a high priority for health. The American consumers are subsidizing a non-system that fails to deal with basic health needs at a cost of two-and-one-half times the general price level. No amount of mental or moral gymnastics or clever Madison Avenue public relations can hide the ugly facts about the failure of our health system."[2]

Although the United States spends a larger percentage of its Gross National Product and more money per person on health care than any other nation, we are slipping in our ranking among the nations on key health indexes. Since 1950 we have gone from first to seventh in maternal mortality, from seventh to fourteenth in infant mortality, and presently rank eighteenth in male life expectancy. In 1970 white infant mortality declined, while non-white infant mortality, nearly twice that of whites, rose significantly. Non-white mothers die four to five times as often in childbirth. A poor person is four times as likely to die by age 35. Clearly, Americans are not getting the health care they have a right to expect.

Specific Problems

1. *Shortages, misuse, and maldistribution of personnel and facilities*

There is inequitable distribution of health care resources, severe shortages of some kinds of health care personnel, and lack of medical facilities in many communities. Important sectors of the community are not able to obtain adequate health services; these groups include the poor, people in rural areas, and in recent years they increasingly include middle-income families. There are severe manpower shortages in the health service fields: primary care physicians, nurses, technicians and supportive services. The number of physicians providing *primary patient care* has decreased from 103 per 100,000 population in 1950 to 90 in 1971, although there is an increase in the number of physicians in all forms of service and the total number per 100,000. Moreover, health professionals are not equitably distributed geographically. In California there is a practicing physician for every 625 persons, twice as many as in seven other states. There are over 100 counties in the United States with no physician. Urban ghettos have lost most access to personal physician care.

adequacies in health care are not entirely due to a shortage of facilities and professional personnel. There is inefficient utilization of personnel and facilities that do exist.

2. *Costs and financing*

a) Spiraling costs have placed adequate medical care beyond the grasp not only of 45 million persons below or near the poverty line but also of many middle-income families. The cost of health care has been rising much more rapidly than other items in the consumer price index. In terms of 1967 dollars, for example, food that cost $74.50 in 1950 cost $119.20 in 1971. The total bill for personal health care for Americans (combining private and public payments) rose from $12.1 billion in 1950 to $26.4 billion in 1960 to $75 billion in 1971.[3]

One factor in inflating costs is lack of coordination and planning in acquisition of expensive equipment. One study[4] showed that almost one-third of those hospitals with expensive open-heart surgery facilities had not used them in a year. Unless there are adequate mechanisms to control the factors producing higher costs, larger and larger segments of our population will not be able to afford medical care.

b) Financing—There is no comprehensive system for financing health care in the United States, one which equitably distributes costs. There are many governmental and private systems, each reaching a segment of the population with varying degrees of effectiveness. During the decade of the 1960's approximately one-third of consumer health expenditures were met by health insurance.[5] One program, Medicaid, designed to provide care to the medically indigent failed to do so to a substantial extent. An HEW Task Force on Medicaid and Related Programs in 1970 reported: "only about one-third of the 30 to 40 million indigent and ically indigent who could potentially be covered (by Medicaid) will in fact receive services . . .", "the cost of covering less than one third has exceeded earlier estimates of the cost of covering the whole medically deprived population."[6]

Especially vulnerable in the under age 65 population are 13% not covered by hospitalization insurance, 20% without surgical insurance, and 57% who have no insurance to cover visits to doctor's offices or home calls by physicians. Insurance policies are designed with the company's rather than the consumer's interest in mind.[7] In 1969, 17 cents out of every dollar paid to an insurance company in health insurance premiums were retained for operating expenses, additions to reserves and profits. The comparable figure for Blue Cross-Blue Shield plans was 4 cents.[8] The cost of administration of public programs from fiscal 1968-1971 was 2.6% of total expenditures.[9]

Policy-holders in private insurance companies, including Blue Cross and Blue Shield, are unprotected or under-protected when they most need help: when they face extraordinary medical expenses or when they seek preventive care to avoid future expenses. This distorts priorities of care and interferes with effective functioning of the health care system.

3. *Inadequacies in the delivery system*

Health services are fragmented, with wide gaps in service, failing to provide continuity of care. This is particularly true when the patient may require attention by his family physician, one or more specialists including surgeons, convalescent care, and post-hospital follow-up care. Even a person with substantial resources now has trouble making effective use of a fragmented system. A low-income person finds it well-nigh impossible.

The current emphasis in medical care is on treatment of crisis illnesses, with relatively limited attention to "health maintenance" which would include prevention, early detection, and treatment during the initial phase of the illness.

Many factors contribute to denials of health care: inability to pay, distance from resources, discrimination based on race or ethnicity, place of residence, and ignorance regarding rights. Treatment of disease for a fee has all too often preoccupied providers to the neglect of health promotion and prevention of illness.

4. *Lack of controls for assuring quality care*

There are substantial variations in the quality of medical care. One is impelled to conclude that existing mechanisms are inadequate to assure quality control at reasonable cost, particularly for health services given outside a medical institution. Hospitals have medical reviews by peer groups, supervision by chiefs of staff, or other internal controls. The effectiveness of these controls varies widely and in many cases is seriously deficient.

For patients outside a hospital, controls tend to be limited to consultation or malpractice suits. There is no unified control system, but rather an agglomeration of relatively independent, self-regulating and diverse enterprisers and enterprises. The accreditation of hospitals, for example, is carried out by the Joint Commission on Accreditation of Hospitals, which is mainly supported by and controlled by The American College of Physicians, American College of Surgeons, the American Hospital Association, and the American Medical Association. All four are organizations of providers. The Joint Commission itself has no effective voice of consumers in its policy-making and standard-setting decisions. Blue Cross Associations, which are supported by its subscribers, are governed by Boards of Directors consisting mostly of health service providers or their representatives.

* * *

These problems are individually identifiable but interrelated. They reflect the fact that there is no national health policy that provides for the development, organization and delivery of comprehensive health care. In the absence of such a policy, unified goals and coordinated plans for meeting the nation's health needs do not exist. What is needed first is a national policy, which is based on the interrelatedness of relevant factors and which in turn furnishes the basis for a comprehensive health-care plan.

The following principles and recommendations are presented in an attempt to indicate some bases for such a plan.

FOOTNOTES

1. "Heal Yourself" Report of the Citizens Board of Inquiry Into Health Services for Americans, Frontispiece (University of North Carolina).
2. Hilleboe. H. E., M.D. "Preventing Future Shock", American Journal of Public Health, Feb., 1972, pg. 140.
3. Social Security Bulletin, U.S. Department of Health, Education and Welfare, Sept., 1971, pg. 52.
4. H.E.W. White Paper: "Towards a Comprehensive Health Policy for the '70s" (May, 1971).
5. "Why Health Security," Committee of National Health Insurance, July 7, 1970, pg. 19.
6. U.S. Department of Health, Education and Welfare, Office of the Secretary, Report of the Task Force on Medicaid and Related Programs, June, 1970, pg. 2.
7. "Heal Yourself" op. cit., pg. 24.
8. Social Security Bulletin, H.E.W., Feb., 1971, pg. 17.
9. Social Security Bulletin, H.E.W., Jan., 1972, pg. 9-11.

PRINCIPLES AND IMPLEMENTING RECOMMENDATIONS

1. The World Health Organization has stated:

> Enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being

without distinction of race, religion, political belief, or economic and social conditions.

Programs in the United States for financing and delivering health care should meet this standard.

II. Since health care systems vitally affect everybody, rich and poor, they must be accountable therefore to the general public at all levels of policy formulation and administration. Consumers (i.e. non-providers) of health care must have a primary role in defining goals and establishing guiding policies of the system.

1. Local communities should be empowered, under a national health policy, to define goals and to obtain services they need. Responsibility should be vested in a community health care policy-making body which will be composed in such a way that the dominant voice in decision-making shall be that of consumer representatives. These representatives should be accountable to organization people who do not derive any part of their income from provision of health care or the health industry.
2. Professional judgments and responsibility of physicians for diagnosis and treatment of individual patients should be assured.
3. Patients' right of choice among alternative providers and treatment plans should be protected.
4. There should be systematic efforts to develop an informed public that has increasing competence to make wise decisions and to create systems conducive to personal and corporate health.
5. The national health care system should provide for flexibility and pluralism in policy-making organizations to allow for regional differences and local self-determination of health priorities, for changing consumer demands and provider services.

III. The Health Care System should be comprehensive with respect to services and facilities provided and to participation of all relevant groups in planning and administration.

1. The following personal health services are essential and should be made available to all people in the United States:

    a) ready access to primary health care and ready referral for preventive and curative services, without exclusion.
    b) Emergency care.
    c) Hospital inpatient and outpatient services, clinic service for diagnosis and acute short-term care for both physical and mental illness.
    d) Long-term hospitalization or other extended care in facilities which provide nursing, therapeutic and rehabilitative services; for both physical and mental illness.
    e) Dental care.
    f) Prescribed drugs.

  - g) Home health services, outreach and intake service, including transportation, nutrition consultation, personal and family health education, medical social services, physical therapy.
  - h) Family planning services. (It is to be understood that such services should protect the voluntariness of parents and that abortion is not considered a method of birth control. Moreover, the rights of health care personnel to refuse cooperation in family planning efforts should be respected.)

2. There should be comprehensive, coordinated planning and administration of health care, with publicly disciplined participation of practitioners and support personnel (such as health technicians, paraprofessionals, volunteers, etc.) to provide for maximum appropriate utilization of neighborhood ambulatory care units, general hospitals, medical research and teaching centers, and other specialized formal and folk resources, and to achieve functional cohesion.
3. Provision should be made for continuity in keeping and using medical and social records.
4. There should be appropriate community action to stimulate and develop competence for self-care and mutual primary group care.
5. New incentives should be developed to increase the availability and integration of health practitioners with diversified competence and for local comprehensive community care programs.
6. Physical and mental health programs should be integrated.
7. Provision should be made for regional health structures providing and appropriately relating essential research, training, specialized services, primary ambulatory care, hospitalization, preventive and health promotion programs.
8. Isolated persons and small communities should be provided all needed regular services through local health care units with transportation furnished to enable persons to have services of specialists and specialized facilities when they are needed. Such communities should have effective voice in deciding how the full range of services should be made available to them.
9. The quality of services should be controlled through organized and objectively administered consumer and professional medical evaluations. These mechanisms should include an effective form of peer group review, with adequate input from consumers and other non-professionals.

IV. Funds to support the health care system should be secured through means that are fair and equitable. Social insurance principles which read the risk among a large population should be operative. Funding evices which discourage good personal health practices essential to health maintenance and preventive care should be avoided.

1. A National Health Fund should be established and maintained at

the optimum level by taxes levied according to ability to pay.

2. Direct payment to providers for health services at the time care is given should not be required of the individual patient or his family, except as there is ability and desire to secure services beyond the comprehensive quality care available to all people covered by the National Health Fund. If it is deemed necessary to provide for deductibles (i.e. payment by patient of a stated sum toward each service utilization) in the years of transition to a national health insurance system, the amount should be reasonable and consistent with ability to pay.

V. The health care delivery system should be designed to implement the principle that health care is a right to which every person is entitled.

1. There should be state, regional, or community health authorities, each serving a population large enough to require all the facilities and personnel for comprehensive health care, but small enough enable communities through individuals and representative groups to design and control their delivery system.
2. Each state or regional health agency must arrange for the provision of essential personal health care to all people in its jurisdiction, using whatever agencies for service delivery and methods of payment will most effectively meet these needs. Federal guidelines shall provide incentives to support programs of prevention and early diagnosis and to assure essential services to isolated individuals and small communities.
3. The national health authority shall require that mechanisms and procedures shall be established in each state or region to assure that both quality of care shall be maintained and the circumstances of delivery shall be acceptable to the people served.
4. In selection of staff and in provision of services all forms of discrimination shall be eliminated: of race, creed, ethnic background, sex and age. Staff able to speak the language of consumers of the service should be provided.

VI. All necessary components for the provision of health care shall be planned for and adequately supported.

1. *Manpower.* There shall be effective utilization of all types of health manpower: professional, paraprofessional and non-professional. In areas where some types are in short supply, provision should be made for professional education, technical training of additional persons, or relocation of an existing surplus from elsewhere by providing appropriate incentives and career opportunities. This will involve:

    a) Making an inventory of existing health manpower as to numbe types of competences, and location;
    b) Identifying shortages and surpluses, maldistribution and inefficient use of manpower;

   c) Improving and making better use of educational resources already available and, when necessary, creating new educational programs to fill shortages in health personnel;
   d) Eliminating shortages caused by limited access to professional education;
   e) Utilizing health personnel from other countries with due concern for the health needs of the countries from which they come.

2. *Research.* A certain proportion of the National Health Fund should be earmarked for research into causes and cures for diseases threatening the health of Americans and for studies to explore more effective methods of delivering health care. The national health agency should contract with national, state, or local agencies or institutions for stipulated research projects, according to a national plan based on information from all regions of the country, from all professional health disciplines, and from consumers representing all economic and ethnic groups.
3. *Facilities.* The development of facilities for provision of health services should reflect community-determined needs for services. This will call for health planning agencies (cf. II above) at local, regional, and national levels which are given responsibility and authority to do the following:

   a) review service programs of all health providers in their areas;
   b) determine needs for service independently of existing service patterns;
   c) make public the information about differences between needs and services;
   d) formulate a plan for facilities and services which will functionally correlate facilities, services, and needs.

Role for Churches and Synagogues

Members of the Task Force believe that churches and synagogues, specifically because they are religious organizations, have a responsibility to participate in the great national debate on changes in the health care delivery system. Human rights and the dignity of persons are ill-served by much of the present health establishment. This is a violation of moral principles and calls for thoughtful and determined action on the part of organizations.

Our Judeo-Christian faiths are founded on convictions about man as well as convictions about God. These convictions must be made relevant by working for a program of legislation which will make possible the physical and mental health of the people of the United States, and by orking with others in achieving the same goal for all people.

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THE NEED FOR A NEW HEALTH CARE POLICY

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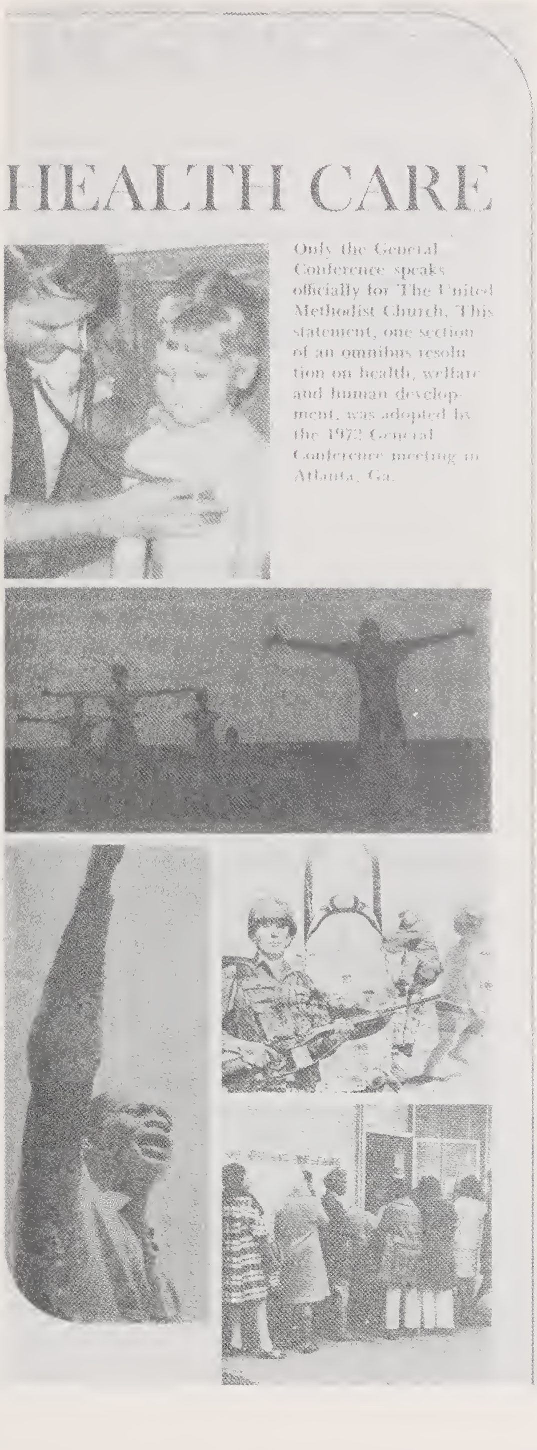

HEALTH CARE

Only the General Conference speaks officially for The United Methodist Church. This statement, one section of an omnibus resolution on health, welfare and human development, was adopted by the 1972 General Conference meeting in Atlanta, Ga.

In order to provide basic needs such as food, clothing shelter, education, health care and other necessities, ways must be found to more equitably share the wealth of the world.

We applaud medical science for efforts to prevent disease and illness and for advances in treatment that extend the meaningful life of human beings. At the same time, we assert the right of every person to die in dignity, with loving personal care and without efforts to prolong terminal illnesses merely because the technology is available to do so.—from the Statement of Social Principles of The United Methodist Church.

HEALTH CARE

We affirm that in an affluent society unimpeded access to adequate health care is a fundamental right of all citizens and is corollary to the right to life itself.

In spite of technological advances which have produced tremendous medical progress in the past twenty-five years there are many problem areas needing drastic attention and correction. Health care in the United States is described today as in a state of crisis. The signs of crisis are clear:

1. The health professions are seriously understaffed and unequally distributed.
2. Health facilities are over concentrated in some areas, under concentrated in others, non-existent in some.
3. In 1969 there were no physicians at all in 134 counties in 28 different states.
4. Some citizens receive inappropriate or unnecessary care while many others are denied access to basic services.
5. We realize mortality rates are not determined solely by available health services. Poverty, poor nutrition, poor housing and lack of education as well as automobile accidents, high cholesterol diet, smoking, the consumption of alcohol and the pace of our society are major contributing factors in mortality rates. Nevertheless, it is shocking to note that:
    - a. In 1967 most industrial nations had lower infant mortality rates than the United States.
    - b. Eighteen nations have a higher male life expectancy rate than the United States.
    - c. There is gross disparity in health between the races in the United States, i.e., non-white infant mortality rates are

nearly double that for white infants.

d. People in poverty have three times the chronic sickness rates of those in middle and upper economic groups.

In spite of its great technical achievements, in spite of long hours of conscientious work on the part of the majority of those in the health care professions, the health care delivery system in the United States is seriously deficient. The costs of that relatively unplanned, unmanaged and uncontrolled system are rising at a frightening pace. The total health bill for Americans, combining private and public payments, rose from $12.1 billion in 1950 to $26.4 billion in 1960, $38 billion in 1965, $67.2 billion in 1970, and $75 billion in 1971. If no changes are made in our present system of health care delivery, government officials estimate total health care costs for the United States in 1974 will reach $105.4 billion.

Under the various legislative proposals to change the health care delivery system presently before Congress, there would not be a significant difference in cost. None of the proposed plans is projected to cost less than $107.2 billion (Bennett plan) nor more than $113.8 billion (Kennedy plan) in 1974. The significant cost differences in these plans is in the various degrees to which the public sector would participate. Under the present system the various government agencies would contribute $43.1 billion in 1974. Under the proposed new plans the governmental agencies may be called upon to contribute as much as $97.9 billion (Kennedy plan) or as little as $45 billion (Bennett plan). Thus while the increase in total cost of health care projected in 1974 under all new plans is less than 10%, the tax burden could increase as much as $54.8 billion in fiscal 1974. (A study of National Health Insurance Proposals, Office of the Actuary, HEW, July, 1971).

A significant portion of the rising costs of health care is due to increases of population, improved but costlier medical technology, wage improvements for health care workers long grossly underpaid, and new programs of health care for the aged and the poor who previously had far too little access to care. Another significant portion of the rise in costs, however, is due to inefficiencies, lack of planning, mismanagement in the system and fear of malpractice suits.

We have noted the variety of current legislative proposals for providing more and better health care for Americans. The proposals range from those which would restructure the system to those which would do nothing other than provide more money for the present system. We oppose such proposals as the latter, seeing profound need to effect economies and to reach greater efficiency in the methods by which health care may be planned, organized, administered, evaluated and financed. We believe Mr. Walter J. McNerney, President of the Blue Cross Association, is persuasive when he says: "Health systems are simply not self-regulating. They must be managed. To pour your money into the present system without changing that system, I think would be disastrous." (Statement to the Senate Committee on Finance, Tuesday, April 27, 1971).

Although we recognize that such complex problems cannot be solved quickly, we believe the following represent important principles for the necessary restructuring of the health care delivery system in the United States:

1. All citizens should have equal access to the best available health care, including preventive services, regardless of wealth, social status, or any other conditions.

2. No arbitrary limits should be set about a person's right to choose among available doctors and facilities for medical care, nor

should the doctors be hindered from choosing the type of medical practice they wish to engage in, provided adequate medical standards of competence and responsibility are met in both cases.

3. Health care should be comprehensive, including physical, dental, mental and emotional fields of practice, and should focus on prevention as well as treatment and rehabilitation.

4. National standards of health care service, including national standards of licensure, should be professionally established and kept under continual review and development.

5. There should be national standards, with policy making and planning carried out at regional, state, area and community levels.

6. Consumers should be represented on boards of professionals and public officials to design and administer every level of the national health care delivery system.

7. State and federal governments should increase their financial support for new medical, psychological, dental and nursing schools, in order to enlarge the supply of health personnel, with special attention given to applications from women and all ethnic groups.

8. Provision should be made for increased training and use of paramedical personnel under professional supervision and responsibility.

9. A universal program to provide all basic and necessary health care services should have costs shared by employers, individuals and general revenue funds. Such a program should be publicly administered. The health care industry and health care professionals may be paid for services in a variety of ways, with special incentives to attract health professionals to shortage areas.

Recognizing that new biomedical technologies, such as organ transplants and control of genetic defects, while offering rich potential for enhancing health, also place stress on traditional images and values about human nature, we encourage men of ethical concern in various relevant fields together to engage in the study and direction of these developments. Mental illness is a major health problem in all parts of the world. The Church is challenged to use its resources to make a major contribution to mental health and healing. We encourage our churches:

1. to engage in mental health education through
   a. family life conferences
   b. workshops on parent-child communication
   c. premarital counseling
   d. more adequate sex education;
2. to become involved in community programs for primary prevention of mental illness;
3. to work with other agencies to develop programs and facilities for the care of the mentally disturbed and retarded;
4. to develop pastoral counselling centers to minister to the troubled;
5. to foster cooperative efforts between ministers, physicians and other health professionals in the care of both the physically and mentally ill;
6. to promote the rapid establishment of community mental health centers;
7. to encourage the establishment and improvement of local and state mental care institutions.

Since universal national financing should be coupled with regional or local administrative units which will allow diversity and real independence, subject to certain basic national regulations, we call upon our churches to be alert to the new opportunities here. Church men and women may become involved in these new approaches to a serious problem not only through community action and planning, but through volunteer service in medical centers and innovative ministries within their congregational life.

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HEALTH POLICY

A Statement of the 183rd General Assembly (1971) of the
United Presbyterian Church

TOWARD A NATIONAL PUBLIC POLICY FOR THE ORGANIZATION AND DELIVERY OF HEALTH SERVICES

Introduction

"I have come that men may have life, and may have it in all its fullness."
John 10:10 (NEB).

A. **Our vision**, illuminated by the Judaeo-Christian understanding of history, sees that God's holy purpose is for mankind to be of worth and be well, and to be in health and nurturing health for one another, in institutions and with the whole world. In faith our vision sees both the promise and the present realities and faces up to ill health and its causes, because it knows a well-being, a life in which we share despite disabilities and illness. We acknowledge a commitment under God, to exercise public compassion and justice for all citizens of our land, and therefore, to increase the public well-being.

We know health is a mutual enterprise, "everybody's business." We recognize that as Presbyterians we are each involved in self health care, in mutual health care in our primary social groups and in supporting health care services at home and abroad among and for our neighbors. What happens to our neighbors' health happens to us. We are all involved directly and indirectly in meeting health care needs, just as significantly as we are each consumers of health care. By the same participation, we are each both shapers of societal and governmental policies concerning health care and recipients of the fruits of those policies.

In the face of those mutual responsibilities, we confess mutual culpability for the fractured and ailing condition of health care delivery in our nation, today, and for the shortsightedness of our nation in failing to participate appropriately in the development of effective health care for all the peoples of the earth.

We do rejoice in the care and devotion, the art and skill of a growing company of health care providers, as we rejoice in the explosion of medical science and technology, and in the innovative institutional and systemic efforts that lead toward a more effective delivery of health care.

B. **We find** that our society is giving highest priority to the production and consumption of goods and to profit-making and to the defense of wealth to the neglect of basic human needs including health.

President Nixon, in July of 1969, said, "We face a massive crisis in this area (of health care) and unless action is taken, both administratively and legislatively, to meet that crisis within the next two to three years, we will have a breakdown in our medical care system which could have consequences affecting millions of people throughout this country."

Fortune, in January, 1970, described the crisis: "American medicine, the pride of the nation for many years, stands now on the brink of chaos."

The worsening health care crisis is characterized by the continuing lack of a comprehensive national health policy and program reflected in inequitable distribution of health care resources, severe shortages of health care personnel, lack of medical facilities, spiraling unbearable costs for services, and an inadequate definition of health care for our time.

National Priorities and Health Policy

A. We believe that good health is one of the nation's most valuable resources, important not only to the well-being of individuals but also to the nation. The development and preservation of good health requires a national commitment with well defined purposes and explicit goals. We believe that health care, though now predominantly an endeavor of private and independent sectors, cannot be left to private resources and private initiatives alone. We believe the general public has direct responsibilities in redesigning and developing a comprehensive, publicly-oriented national health policy.

B. We find that there is no national health policy that provides for the development of the organization and delivery of comprehensive health care. In the absence of such a policy, unified goals and coordinated plans for meeting our nation's health needs do not exist. The confusion over goals is the major obstacle to an effective system of organization and delivery of quality health care. It is crucial, therefore, that there be a national policy to guide the restructuring of responsibility and accountability within the health care enterprise.

C. **Therefore, we recommend that:**

1. There be developed a national policy leading to a comprehensive system of health care which shall:
    a. Be accountable to the general public;
    b. Make all services and benefits available to all persons in the United States;
    c. Be administered by a single national health agency with power to enforce standards to provide the highest quality health care possible.
2. The purview of the national health agency include, within the full range of public, private and voluntary health facilities, service and agencies:
    a. Health promotion, health maintenance, prevention of illness, diagnosis and treatment of disease, and rehabilitation;
    b. Research and planning:
    c. Manpower development and deployment;
    d. Financing;
    e. Evaluation and assessment of needs and services, and recommendations for improvement and their implementation;
    f. Optimum development of each phase of daily activities, such as school and place of work, as the setting for health care.

Process of Accountability in the Health Care System

A. **We believe** that health care is everybody's business, a mutual enterprise. Health care must be accountable to and under the control of the general public with decentralization of authority to make it responsive to the needs and desires of local communities and effective in providing consumer care.

Of paramount importance in the development and implementation of public health policies is the involvement of the consumer community. The involvements of the consumer stems not only from his self-interest in sharing the benefits of health sciences, technology and skills, but also from a concern for the right of all men to adequate health care based on need rather than on the ability to pay as the present system requires.

New frontiers in health care should develop a system that will achieve participation of all segments of society in defining objectives and priorities, guiding change and development in health care resources and services, and in surveillance of the performance and responsiveness of the health care system.

B. **We find** no unified control system, but rather an agglomeration of relatively independent, self-regulating and diverse enterprisers and enterprises. Some are harmfully competitive, and almost none is effectively accountable to the general public and consumers of health services. There are current vested interest groups that resist redefining purposes and goals. The consumer must help redirect policies and procedures. Therefore, the empowerment of consumer groups as a distinct element in policy-making and program development is essential. Otherwise, the current arrangements for delivering health care will continue to be dysfunctional. We will continue to have a shortage and improper utilization and maldistribution of health personnel and facilities, and we will continue to have costs spiraling beyond the reach of the vast majority of people.

C. **Therefore, we recommend that:**

1. The complex issue of health and health care be redefined as a public issue, affecting rich and poor alike, rather than a professional and management problem to be solved by a few, whether in public or private capacities;
2. The organization and delivery of medical and other health services be directly accountable to the general public at all levels of policy formulation, determination, and administration;
3. Local consumer groups be empowered, under a national health policy, to define goals and obtain what they need, as well as to check and balance the providers of health care services;
4. There by systematic efforts to develop an informed public that has increasing competence to make wise decisions and to create systems conducive to personal and corporate health;
5. Quality control of services delivered be established through organized and objectively administered consumer and professional medical evaluation;
6. There be flexibility and pluralism in the policy-making organization of the system to allow for regional differences and changing definitions of consumer demands and provider services;
7. There be established national guarantees and mechanisms for the execution of policy to protect the right of the patient and physician to make free decisions about medical treatment.

The Delivery of Health Services

A. **We believe** that the value of persons requires that each person have full access to essential services without regard to ability to pay and on terms that enhance the dignity of individuals. We believe that the needs of the whole person must be addressed in the context of his whole milieu. We understand such care to include attention to physical and dental, mental, social and environmental needs. We believe that only with a continuity of personal relationships in a health providing community and a continuity of access through comprehensive health services will adequate care be achieved. We believe that an understanding of what a person can do individually and in his primary social group to promote and protect his own health has high priority for developmental assistance. We believe that personal and local self-determination of health priorities is necessary for the proper correlation of needs and resources.

B. **We find** our medical system to be preoccupied with disease and crisis care, which is costly in lives, social relationships, and money. A recent study showed that almost one-third of those hospitals with expensive open heart surgery facilities had not used these in a year. We find that although the United States spends a larger percentage of its Gross National Product and more money per person on health care than any other nation, we are slipping in our ranking among the nations on key health indexes. Since 1950 we have gone from first to seventh in maternal mortality, from seventh to fourteenth in infant mortality, and presently rank eighteenth in male life expectancy. An inequality exists and is growing in our country. Last year white infant mortality declined, while non-white infant mortality, nearly twice that of whites, rose significantly. Non-white mothers die four to five times as often in childbirth. A poor person is four times as likely to die by age 35. And the National Urban Coalition, supported by data from the Social Security Administration, states that spiraling medical costs have placed adequate medical care beyond the grasp of at least 45 million persons below or near the Census Bureau's poverty line.

We find that people are not receiving the care they need. Specialized practitioners and specialized facilities have focused on isolated conditions with services that leave unattended the other commonplace acute and chronic individual and family disorders, much less their causes. Inability to pay, distance from resources, discrimination regarding race and ethnicity, place of residence, and ignorance regarding rights have all contributed toward denying health care that is a rightful human heritage. Treatment of disease for a fee has all too often preoccupied the providers to the neglect of health promotion and prevention of illness. We also find that available services are fragmented and uncoordinated, and often perilously concentrated in some locals.

C. **Therefore, we recommend that:**

1. Comprehensive health care for all persons include at least these elements: aid in growth and development, nutrition, prevention of illness, periodic diagnostic evaluation, treatment of disease, extended and home nursing care, rehabilitation, long term care for chronic disorders, and the appropriate social and economic provisions to make these feasible in the life of a person and his household;
2. There be comprehensive, coordinated planning and administration of health care with publicly disciplined participation of practitioners, support personnel such as health aid technicians, paraprofessionals, volunteers,

etc., neighborhood ambulatory care units, general hospitals, medical research and teaching centers, and other specialized, formal and folk resources to maximize the appropriate utilization of each and to achieve functional cohesion;

3. There be appropriate community action to stimulate and develop competence for self-care and mutual primary group health care;
4. New incentives be developed to further the availability or group practice by health practitioners with diversified competencies for local community comprehensive care;
5. State laws prohibiting group practice be repealed;
6. Group practice units be linked with hospitals and other back-up units to offer prepaid, health promotion-oriented care on a per capita basis;
7. Physical and mental health programs be integrated;
8. Regionalization of the system be established with each region providing and appropriately relating essential research, training, specialized back-up services, primary ambulatory care, hospitalization, preventive and health promotion programs;
9. Health care units be established as needed to serve isolated persons as well as local communities with provision for community self-determination of priorities and full care guaranteed all community residents;
10. Appropriate programs be instituted to stimulate optimum local community development of health care.

Personnel Resources for Health Care

We believe that the recruitment, preparation, and utilization of health manpower deserve high priority. Responsible management and efficient delivery of quality health care requires competent health professionals and allied personnel, well-distributed, and optimally utilized. Health careers should assure opportunity to exercise humanitarian and social responsibility, and provide both lateral and vertical career mobility. Opportunities must be open equally to all regardless of age, race, sex, or ethnic origin.

Practitioners must be able and encouraged to keep abreast of new knowledge, technology, and delivery systems. They must participate in continuing research and improvement of their professions, and must be adequately remunerated with due regard to their usefulness and personal need. And they must be accountable to the general public and the consumer community they serve.

We find that there is a serious shortage of health personnel and no rational system to develop and employ adequate manpower, nor to assure maximum utilization and appropriate development. The U.S. Public Health Service estimates that we face current shortages totalling 481,000 including 48,000 doctors, 17,000 dentists, 150,000 nurses, 105,000 environmental health specialists, and 161,000 other health professionals. By 1980, this personnel shortage will probably climb to an estimated 775,000, yet approximately 15,000 applicants are annually rejected from medical schools, primarily by lack of space. We import 8,000 doctors a year, mostly from underdeveloped countries, who need them even more than we do; and still there are 11,000 hospital residencies unfilled. Because of migration of doctors to the suburbs, doctor shortages are most acute in the areas of greatest need--the central cities and remote rural areas.

While extraordinary efforts must be made to significantly increase the number of doctors, the increased use of allied professionals and paraprofessionals (many already trained in the military, peace corps, etc.,) offers a means of improving and expanding health care more rapidly and more adequately than by increasing the number of doctors alone.

Intelligent planning and action is needed now not only because of the present shortage of manpower but, also, because of the expanding number of health occupations, problems of accreditation, deficiencies in educational programs, and the requirements of future programs to provide essential health care.

C. **Therefore, we recommend that:**

There be a national health agency to formulate and administer public policy such as to:

1. Determine how the medical personnel resources of the nation might best be apportioned and related to develop programs to assure the just distribution of such personnel through voluntary choice;
2. Establish guidelines for expanding, organizing, and utilizing the supply of health manpower, including all levels of needed knowledge and skill;
3. Foster the creation of new health careers and new training resources for assistants and aids;
4. Provide functional, national licensure criteria for all health occupations:
    a. Facilitating unrestricted opportunities for career enlargement and advancement;
    b. Facilitating geograpnical mobility within the nation;
    c. Fostering optimal use of time in preparatory education and facilitating early placement.
5. Develop criteria and establish programs to encourage educational institutions to:
    a. Extend their capability to develop qualified health personnel for all categories of need in sufficient number to meet current and future demands;
    b. Increase enrollment and training in health professions and occupations;
    c. provide continuing education and training for health personnel and opportunities for career mobility;
    d. Stimulate through incentives and other means the recruitment for health professions and occupations from sections of the population that have been excluded because of economic or racial barriers or because of masculine or feminine discrimination.
6. Develop new educational institutions in areas where they can be of most service to people needing health care.

Financing Health Services

A. We believe each citizen should be eligible for comprehensive and continuous health services regardless of his ability to pay. Such universal coverage implies universal participation in the financing of that care. We believe that the public should get full value for the investments made in health care. We believe the economic arrangements should favor promotion of health and prevention of illness. We believe that the economic rewards in the health care system should be so distributed as to compensate all workers equitably, to promote equitable distribution of health resources among the population, and to cause optimum collaboration among health agencies.

B. **We find** that there are formidable and sometimes insuperable financial barriers to adequate medical services and health care for large numbers of people in the United States. Spiraling costs of such services, which continue to skyrocket at a rate of increase approximately two and one-half times faster than the general price index, threaten to exclude even larger numbers.

Money alone cannot be the answer, particularly if it is used to support the present fragmented nonsystem of delivering health care services. The present arrangement of financing is not adequate to achieve the objective of establishing a unified, coordinated system capable of increasing availability and continuity of care and enhancing its quality, promoting health and preventive medicine as well as the treatment of illness, improving the utilization and effectiveness of all services, and strengthening personnel and financial controls to restrain the escalating costs while providing fair compensation for those providing the knowledge, service, goods,and facilities.

The creation of a viable system and improved financing must take place simultaneously and in parallel.

C. **Therefore, we recommend that:**

1. There be such public investment in financing health care services that every person may be assured quality comprehensive health care, independently of an ability to pay, and without discrimination because of economic status, color, sex, religion, or political affiliation;
2. Public financing be utilized simultaneously both to facilitate access of every person to essential health care and to create a rational, well organized, economical, and balanced health care system designed to service all persons adequately;
3. A national health agency be empowered to provide leadership in developing and progressively refining objectives, standards, and methods of financing health care, and to regulate the financial operations of the health care system, so that appropriate economics may be realized and accountability to the consumer communities assured.

Enabling Health Services

In the face of the current health crisis, our Lord's concern for the health of all persons confronts us with an immediate urgency. His was a spirit that reached out alike to the leper and the centurion's son, that they might recover wholeness.

A new level of commitment and involvement is required of the Christian community today if we are to be faithful to the example of our Lord's healing ministry.

The varied legislative proposals, which are now before the Congress, dealing with the crisis in health suggest new health care opportunities for many persons. But the wide divergency of possible application demands a greater level of public determination in order to assure a system of comprehensive health care that serves God's purpose for all persons.

Therefore, the 183rd General Assembly (1971):

1. Calls upon all boards, agencies, judicatories, and members of the United Presbyterian Church to initiate and vigorously support actions affirming the recommendations of this statement.

2. Requests the appropriate agencies of the church to provide resources that will help United Presbyterians to deal knowledgeably and constructively with problems of health care and medical services.

3. Urges federal, state, and local governments to take prompt action to affirm, through appropriate legislative and administrative action, the right of all persons to full access to comprehensive health care without regard to ability to pay, and on terms specifically accountable to the public.

United Presbyterian Church, U.S.A.
Department of Church and Society
830 Witherspoon Building
Philadelphia, Pa. 19107

Appendix

Organizations and constituent bodies officially supporting this testimony

Group:	*Membership*
Friends Committee on National Legislation	200
United Methodist Church—Board of Church and Society	90
Church of the Brethren	183,000
United Presbyterian Church, U.S.A	3,000,000
Union of American Hebrew Congregations (700 congregations	1,000,000
Network	3,000
United Church of Christ Center for Social Action	1,800,000
Christian Church (Disciples of Christ) Department of Church in Society	1,200,000
Jesuit Conference	6,000
National Council of Jewish Women	100,000
National Council of the Churches of Christ in the U.S.A. (representing some 31 Protestant and Orthodox denominations) listed below	40,519,913

TABLE 1.—CONSTITUENCY OF THE NATIONAL COUNCIL OF THE CHURCHES OF CHRIST IN THE UNITED STATES

Religous body	Year	Numbers of churches	Inclusive membership	Pastors serving parishes
African Methodist Episcopal Church	1951	5,878	1,166,301	5,878
African Method'st Episcopal Zion Church	1973	5,994	1,024,974	6,700
American Baptist Churches in the United States	1973	6,020	1,502,759	4,930
The Antiochian Orthodox Archdiocese of Toledo, Ohio, and Dependencies in North America	1971	16	30,000	19
The Antiochian Orthodox Christian Archdiocese of New York and All North America	1970	92	100,000	96
Armenian Church of America, Diocese of the (including Diocese of California)	1972	58	372,000	62
Christian Church (Disciples of Christ)	1973	4,544	1,330,747	4,081
Christian Methodist Episcopal Church	1965	2,598	466,718	2,214
Church of the Brethren	1973	1,035	179,333	847
The Episcopal Church	1973	6,768	2,917,165	7,307
Friends United Meeting	1972	515	68,717	299
General Convention, The Swedenborgian Church	1967	56	4,450	34
Greek Orthodox Archdiocese of North and South America	1972	502	1,950,000	545
Hungarian Reformed Church in America	1969	27	11,250	24
Lutheran Church in America	1973	5,767	3,017,778	4,883
Moravian Church in America:				
Northern Province	1973	98	33,321	82
Southern Province	1973	50	22,411	49
National Baptist Convention of America	1956	11,398	2,668,799	7,598
National Baptist Convention, U.S.A., Inc	1958	26,000	5,500,000	26,000
Orthodox Church in America	1973	375	1,000,000	395
Philadelphia Yearly Meeting of the Religious Society of Friends	1967	202	[1] 16,965	[1] 23
Polish National Catholic Church of America	1960	162	282,411	151
The Presbyterian Church in the United States	1973	4,347	906,359	NR
Progressive National Baptist Convention, Inc	1967	655	521,692	NR
Reformed Church in America	1973	905	360,746	880
Russian Orthodox Church in the United States, Patriarchal Parishes of the	1973	41	51,000	54
Serbian Eastern Orthodox Church for the United States and Canada	1967	52	65,000	56
Syrian Orthodox Church of Antioch	1972	10	50,000	14
Ukrainian Orthodox Church in America	1973	23	30,000	22
United Church of Christ	1973	6,617	1,867,810	4,992
The United Methodist Church	1973	39,395	10,192,265	20,130
The United Presbyterian Church in the United States of America	1973	8,688	2,808,942	7,398
Total (31 bodies)		138,888	40,519,913	105,763

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[1] 1965.

Note: A separate tabulation has been made of the constituent bodies of the National Council of Churches of Christ in the United States.

STATEMENT OF LEROY H. JONES, CHAIRPERSON, HEALTH ADVISORY COMMITTEE OF THE COUNCIL FOR HEALTH AND WELFARE SERVICES ON BEHALF OF THE UNITED CHURCH BOARD FOR HOMELAND MINISTRIES

The United Church of Christ, with a total membership of approximately two million persons, has a long and unique history of being both advocates for and providers of health care services. Related to the Division of Health and Welfare of the United Church Board for Homeland Ministries are:

53 facilities for the Aging, which include nursing care and housing for low-income elderly, some of which also provide non-residential services.

5 Centers, which provide services for the developmentally disabled.

5 settlement and neighborhood houses.

15 agencies providing services for children, including residential and non-residential treatment programs, and

11 general hospitals, including outpatient services and schools of nursing.

The United Church of Christ has always been an exponent of "the highest attainable standard of health as one of the fundamental rights of every human being". The United Church Board for Homeland Ministries issued a Statement of Policy on National Health Care on October 20, 1971. In September 1972 the Inter-Religious Task Force on Health Care approved a statement entitled "The Need for A New Health Care Policy in the United States" which drew heavily on the Board for Homeland Ministries (BHM) statement. In July 1975, the Tenth General Synod of the United Church of Christ adopted the 1971 B.H.M. statement of policy. Over the past year and a half, many instrumentalities of the USS, concerned with health care, have sponsored regional health care consultations throughout the country. These were directed at raising the health care issue as a top priority and designed to involve people in working for a comprehensive national health care program. These efforts are continuing. On July 1, 1974, we presented oral testimony before the House Ways and Means Committee, and on April 14, 1975, we submitted a written statement to the Subcommittee on Health of the Ways and Means Committee. We are appreciative of this opportunity to once again present our views.

It is almost a century since Bismark took the initiative in developing a national health care system for Germany, yet this country is still grappling with the question of "what kind of health insurance should the United States have"? This question has been pondered continually since 1915. A great deal of information has been compiled on the issue; we have had 45 years of experience with voluntary health insurance and almost 10 years with Medicare and Medicaid. As a result we should now be in a better position to answer the question "what kind of health insurance". Yet, have we learned from these experiences? It does not appear so, unfortunately.

It is imperative, now and then, to review history to see if it can offer any insight into why we as a nation have failed, despite increasing attempts, to make quality medical care available and accessible to all. Such a review may also shed some light on what should be done in the future. Following is a quick look at how the U.S. has attempted to deal with its health problems over the past few decades. It is our contention that efforts, up to now, have not been properly focused and have perpetuated the crisis we set out to solve. The question for all of us now, as we once again consider national health insurance, is—Are we destined to continue this trend?

1. *The categorical Approach*

Up to now problems have been dealt with in a categorical manner as if one problem, or set of problems, was completely disassociated from another. Examples include Medicare, Medicaid, Neighborhood Health Centers, Maternal and Child Health programs, Migrant Labor Health programs, etc. Each has its own administrative requirements and its own eligibility criteria that often conflict with one another, which results in duplication, waste, excessive bureaucracy, confusion and misunderstanding. There has been no successful attempt made to co-ordinate programs to see how all these parts fit together, or to take a global or comprehensive approach. In the absence of a suitable mechanism, there has never been any kind of co-ordinated long-term planning, which is absolutely essential if both short term and long-term problems are to be solved. Senator Ribicoff recognized this in 1968, when he said:

"Because we rely so heavily on the programatic approach—passing a program whether we discover a problem or a part of a problem—and rely so little on a comprehensive manner—our efforts often are marked by confusion, frustration and delay".[1]

It seems unfortunate that the Senator has apparently regressed in his perception by introducing and co-sponsoring the Long/Ribicoff catastrophic health insurance plan, which would only add to and perpetuate the patchwork method of problem solving.

2. *No National Health Policy*

It is quite clear that many of the problems the American people face in finding and financing medical care are due in large measure, to the fact that this country does not have, and never has had a national health policy. The Department of H.E.W. has truthfully acknowledged this fact. In response to a question regarding the implementation and formulation of national health policy it stated:

"Up to and including the present, there has never been a formulation of national health policy, as such. In addition, no specific mechanism has been set up to carry out this function. As a consequence, the national health policy is a more or less amorphous set of health goals, which are derived by various means and groups within the Federal structure." [2]

The absence of a central policy making body for health has resulted in an inability to determine goals, to develop rational programs, to achieve a balance between the different areas (research, manpower, education, etc.) and to evaluate performance. It furthermore results in waste, inefficiency, fragmentation, and high costs.

3. *The Impact of Financing on the Organization of Medical Services*

Policymakers in the past believed that the type and source of financing would determine the type and organization of medical care. This assumption has proven to be erroneous as has been exemplified by the Medicare and Medicaid experiences. If there is one thing that should be learned, it is that the health care system has an insatiable appetite for consuming dollars. Yet more money, in itself, rather than providing incentives for change in the organization of medical care delivery, actually reinforces and perpetuates existing methods.

4. *Maldistribution and Incentives*

Repeated attempts have been made to improve geographic and specialty maldistribution by depending on the "incentive philosophy"—i.e.—leave the allocation of resources to the "invisible hand" of the free market mechanism. What has happened? Has it worked? Mere incentives have not and are not going to provide enough leverage for the required changes that are essential. Orientation in this direction has resulted because of an indoctrination to have faith in the competitive pressures of the market place and the natural law of supply and demand and everything would sort itself out in time. Doctors would practice where the need was greatest and they would enter those specialties that people needed the most. The trouble is that the "free market place" has nearly always done more for people with something to sell than for those who were looking for something to buy. The American system of medical care is mainly a provider's system.

5. *Illness-Oriented*

Traditionally the health care system has been geared toward the treatment of illness rather than to its prevention. Present insurance coverage provides incentives, both to the provider and the consumers, for hospitalization when out-patient ambulatory treatment might be more appropriate. This concept of insuring for the cost of sickness rather than the maintenance of health inevitably leads to increased cost, both to the individual and to society as a whole. It would appear that this orientation is designed, in part, to accommodate existing delivery mechanisms rather than tackle the real health needs of people.

6. *Symptom Versus Cause*

The problems of high costs, maldistribution, etc. have, in the past, been treated as if they were the causes of the present crisis. They are the symptoms, rather, of a structural disfunctioning within the present system, where providers wield an inordinate amount of power and where the desire for profit often takes precedence over the maintenance of good health. Unless this disfunctioning is addressed, all the problems that are being discussed will continue.

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[1] Navarro, Vincente, *National and Regional Health Planning in Sweden*, U.S. Department of Health Education and Welfare, U.S. Government Printing Office, 1974, p. 212.

[2] *Federal Role in Health*. Report of the Committee on Government Operations, U.S. Senate, Apr. 30, 1970, p. 14.

NATIONAL HEALTH INSURANCE—ISSUES AND CHOICES

As the issue of national health insurance is being discussed, a basic question should be—Are the past methods of addressing health care problems going to be continued or are those necessary choices going to be made which are essential if this country is going to move in the direction of making the right to quality health care a functional reality for *all* Americans? National health insurance will not cure all the ills of the present health care system. It can and it must do many things, however.

1. *Universal Coverage*

Any national health insurance plan should cover all US residents and should not exclude anyone because of family composition, employment status, income status or social security contribution history. If coverage is not universal, then the program must, of necessity, distinguish between various categories of potential users. These determinations, probably through the mechanism of a means test, would be socially devisive, highly expensive and complex to administer, and would almost definitely lead to different levels of care for different population groups—in effect, a clearly defined multi-class system of care. Universal coverage is essential if the goal of national health insurance are to be achieved.

2. *Comprehensive Benefits*

Up to now health insurance benefits have developed unevenly. Coverage of hospital care has always been ahead of coverage for other, related services. In consequence, some distortion in use has followed, with the insured service which is often more costly, many times substituted for cheaper, uninsured services. We thereby urge that the benefit package be broad and not continue to reflect the traditional concept of insuring for the cost of sickness rather than for the maintenance of health. The benefit package should reflect a belief in the concept of "positive" health and should include services which until now have been largely omitted from most health insurance plans. A comprehensive benefit package should consist of the following:

(A) *In-patient benefits.*—Related to hospitalization or other health care facilities such as nursing homes and residential treatment centers:

> Professional fees while institutionalized (as long as required); institutional fees; services by paramedical personnel; drugs and other medication; medical hardware; psychiatric services; diagnostic and treatment X-rays; laboratory services; operating room services; and ambulance services.

(B) *Out-patient benefits.*—Preventive health services have for too long been omitted from insurance coverage. The benefit package, therefore, should reflect a preventive health orientation. Out-patient benefits should include the following:

> All services provided in doctors' offices, health centers, HMO's, etc. by physicians, nurses and other health professionals; all prosthetic devices and other needed supplies; prescription drugs; rehabilitative services; screening and early detection services; immunizations; eye examinations and eye glasses; ear examinations and hearing aids; mental health care; dental care; pre-natal care; health education; and home health services.

Providing comprehensive health benefits to the entire population is a major undertaking. There is danger that the existing delivery system may be over burdened and thereby lead to dislocations which may jeopardize the success of the total program. We, therefore, believe that N.H.I. should provide for the phasing in of the components of comprehensive health care benefits as rapidly as resources and revenues allow. Target dates should be set and measured for evaluating their achievement should be clearly delineated. In such a phase-in preventive benefits should be regarded as a top priority.

3. *No Cost Sharing*

This is one of the most contraversial issues in the whole national health insurance debate. We strongly oppose the concept of cost-sharing as a means of controlling over-utilization and/or costs. Cost sharing negates the concept of universality; it places severe barriers to the receipt of service; it places the heaviest burden on the poor and the ill and it is costly and complicated to administer. The cost-sharing idea, furthermore assumes that the patient determines utilization. The fact is that in most cases it is the doctor who makes such a determination.

4. *Equity in Financing*

The two basic methods that have been discussed for financing national health insurance are the payroll tax and general revenues. Looking at the pro's and con's of each, we believe that a balanced combination of both general revenues and payroll tax, with no upper limit, provides at this time the most secure financial base for a national health care program. If we believe in equity and are committed to improving health, we must continue to work for those changes in our tax laws that are essential if fairness is to become a true part of our social welfare system.

5. *Cost-Control*

We can no longer afford to look at cost-control as if it were an isolated issue. We have to look at the totality of our health care system. We have to look at the delivery system, its productivity, its adequacy, its effectiveness and realize that cost escalation and an inept delivery system nurture one another. Any national health insurance plan should require a balanced co-ordinated combination of the following:

Prospective budgeting for health care facilities;

A realistic review and monitory system;

A revamped reimbursement process for physicians which encourage prepaid capitation over fee-for service;

More efficient use of and reimbursement for paraprofessionals and allied health personnel;

Incentives for preventive health care, including expanded health education, both for providers and consumers;

Promotion of group practice and out-patient rather than in-patient care;

More efficient use of the planning process which would foster systemization in the organization of health care delivery.

6. *Consumer Input and Accountability*

The Citizens Board of Inquiry and Health Services for Americans of the American Public Health Association stated in 1972 that health professionals should make individual decisions affecting the health of their patients while the public should become the ultimate determinant of the health care system and of how health care services are delivered, paid for and organized.

This issue of a role for consumers in an often forgotten component in the development of N.H.I. We believe that there should be provision for genuine consumer involvement in the decision making, planning, and evaluation process at every level.

ADMINISTRATION

At present health care is offered by a bewildering array of autonomous individuals and institutions and the equally bewildering array of government programs and agencies. There is no central authority, no coherent organization. By continuing to fragment authority among separate layers of Government and the private sector, we exacerbate problems of coordination and constantly retard the development of systematic planning and policy making. National health insurance, therefore, should through an effective administrative structure co-ordinate all these diverse programs and agencies and thereby provide a mechanism for the development, implementation and evaluation of a national health policy.

The administering authority of a national health care program should:

1. Be appropriately centralized and decentralized—Federal, State, and local levels. To achieve effectiveness and efficiency of operation certain functions must be performed on a centralized level, others on a more decentralized level and others coould and should be performed at all levels. This functional breakdown at different levels is necessary to avoid a monolithic federal administration that may be too distant and unwieldy. In determining what mechanism should have administrative responsibility at the local and regional level close attention should be paid to the new mechanisms set up under the recently passed National Health Planning Resource Development Act of 1974 (PL 93–641) (e.g.—local health service areas. Health systems agencies, etc.);
2. Assure that the program functions effectively and efficiency for all;
3. Be flexible and responsive to necessary changes.

Co-ordination With Other Programs

National health insurance, to be effective, must be closely co-ordinated with other programs areas which have a major bearing on the health care system. Two such areas are presently getting priority. One is the Health Planning and Resource Development Act of 1974 which is presently being implemented. The other is health manpower legislation, already passed the House and presently in process in the Senate. These two issues, planning and manpower, are crucial to the effectiveness of N.H.I. Their progress, therefore, must be closely monitored.

THE LONG-RIBICOFF CATASTROPHIC HEALTH INSURANCE AND MEDICAL ASSSISTANCE REFORM ACT OF 1975—S. 2470

Congressman Rostenkowski in an editorial in the Washington Insurance Newsletter Sept. 8th, 1975, stated:

"We need to know on a long range basis what our objectives are and in a fairly explicit fashion. Our final objective is universal access to health care coverage for a broad range of services. To reach our objective we must construct a program on the basis of an orderly progress or from what we have to what we want."

Those who believe that progress in the health care field must be made incrementally regard S. 2370 as an acceptable response to the health care crisis.

The passage of a catastrophic piece of legislation such as S. 2470, while it would alleviate severe financial hardships for a small number of people (an estimated 1.6 million persons in a recent study done by Michael F. Meyer at the University of Chicago and published by the Heritage Foundation in Washington, D.C.) has severe limitations of which we should all be aware. For example:

1. It assumes that people already have good basic coverage and only require protection against catastrophic illness. The facts demonstrate that this is not so.
2. It would perpetuate the traditional concept of insuring for the cost of illness (in this case serious illness) rather than for the maintenance of health.
3. It would exaggerate cost inflation by adding to incentives for very expensive care.
4. It makes no provision for consumer representation.
5. It increases and strengthens the already powerful position of the private insurance companies who have in the past failed to initiate needed changes.
6. It would increase the fragmentation and complexities of the present financing system and thereby add to cost inflation.
7. It includes no cost or quality controls.
8. It would distract Congress and the public from serious consideration of a comprehensive national health insurance program on the theory that the most serious problems were being dealt with by providing coverage for catastrophic expenses.

The Long/Ribicoff bill, would in all probability be just more of the same. It fails to address any of the major causes of our health care crisis; instead it would just pour in more money and thereby exacerbate an already bad situation. The claim that the bill is economically feasible is a myth. Proponents of the bill fail to tell us that the estimated cost of this bill would just be added on to the existing health bill of $120 billion.

The fact is that simple extension of present activities coupled with a further patchwork approach, will provide no long term solution. We agree with Cong. Rostenkowski when he says that "we must construct a program on the basis of an orderly progress or from what we have to what we want." But passage of catastrophic health legislation is not the way, unless—we want more cost inflation, more maldistribution and inaccessability to care for millions of Americans.

SUMMARY

We urge this Committee and Congress to move with all due haste in the development of a comprehensive national health care program to meet the just needs of the American people. If the Congress finds it necessary to consider phase-in options to health care reform then these options should be clearly identified as part of a long range continuum toward development of a comprehensive national health care program that would make quality health care available and accessible to all as a matter of right.

We thank the Committee for the opportunity to present this statement and we are always ready to be of assistance.

Thank you.

Mr. COTTER. Thank you very much, Father, for a fine presentation. I would like to apologize for the members of the committee. We have a very important vote going on on the floor, the Budget Control Act. That is the reason why there are so few members here.

However, your testimony nevertheless is extremely important to the committee and the members in our deliberations.

So would you proceed, Mr. Thornton.

STATEMENT OF C. VICTOR THORNTON

Mr. THORNTON. Thank you, Mr. Chairman.

I am C. Victor Thornton, I am vice chairman of the board of trustees, and chairman of the Planning Committee of Shriners Hospitals for Crippled Children, in Fort Worth, Tex.

My home is in Fort Worth and the central office of the Shriners is in Chicago.

The purpose of my testimony is to stress the importance of the free hospital system under any national health insurance program that may be adopted.

We do thank the committee for allowing us to testify on this matter.

Shriners hospitals for crippled children are supported by nearly 1 million Shriners. Since 1922, when the first Shriners hospital opened, more than 220,000 crippled and burned children irrespective of race or creed have been treated. The cost of treatment, including capital expenditures, amounted to approximately $340 million through December 31, 1974. During this time, no Federal, State or local financial support was received for patient care. No insurance or similar third party payments were received on behalf of any patients, or, I might add, for buildings and facilities.

No parent or legal guardian of a patient paid for any inpatient or outpatient treatments.

Shriners hospitals for crippled children now has 19 orthopedic hospitals and 3 burns institutes, or units, throughout North America.

Our hospitals care for children under the age of 16 who have a curable crippling condition, or who need burn treatment, and whose families are unable to pay for equivalent hospital services, directly or indirectly, without undue hardship.

The support for our hospitals comes from public contributions and endowment earnings together with fund raising events carried on by Shriners and their families. No health care institution in the United States is so totally free. It is charity in its purest sense and we call it the "World's Greatest Philanthropy." We desire to continue to be as free and as charitable even after the advent of national health insurance to the children who need our care.

In addition to patient care, our hospital system is active in the education of the medical profession. Approximately one-fourth of the certified orthopedists practicing in the United States have received training in Shriners hospitals.

We are also active in medical research and burn care and the side effects of severe thermal injury. Our research discoveries in burn care are well known around the world by the medical profession. In our orthopedic hospitals we are doing orthopedic research in all phases of the causes of crippling including probes into genetic causes.

SCOPE OF NHI COVERAGE

We recognize that the general approach, coverage, scope of benefits, administration, financing, and effect on other governmental programs may vary among the various national health insurance bills pending before the committee.

However, we would like to see legislative and administrative guidelines which will delineate the role which free hospitals, like ours, can play in any future national health insurance system.

All three of our burns units and several of our orthopedic units are closely affiliated with some of the country's greatest universities and hospitals. For example, the Boston Burn Unit is affiliated with the Harvard University and with Massachusetts General Hospital. The Cincinnati Burn Unit is alined with the University of Cincinnati and Cincinnati General Hospital. The Galveston unit is affiliated with the University of Texas Medical School.

Because of this and because of our unique three-faceted program of treatment, research and teaching, we fully believe that under whatever system of national health insurance is adopted, our hospitals can continue to provide services of a type and quality not available elsewhere.

When national health insurance becomes a reality, there should be fewer medically indigent children. Our charity recognizes that certain changes in our admissions standards and the types of cases to be treated will be necessary in order that we can continue to provide needed service.

We believe national health insurance legislation should expressly authorize the Federal and/or State governments to contract specially with providers such as us. The effect of such contracts would be to allocate patients to free hospitals under appropriate circumstances where free hospitals can provide the same quality or special type care to a child that a for-pay hospital can.

The legislation should direct the responsible agency to use the free facilities when, as, and if appropriate.

We recognize, of course, that geographical limits or personal feelings of a patient or the patient's parents may have a role in any decision on the selection of the location, or of the hospital, and we feel these factors would all have a role in how legislation or regulations can be developed to facilitate the use of a free provider health service. By giving some priority and permissibility to using the free system, Federal moneys would be saved. It also means that a free hospital system will be used to maximum advantage in conducting its health care functions.

Next, incentives to giving. We believe the designers of national health insurance must further accept the premise in drafting national health insurance legislation that private philanthropy is essential to the delivery and the continuing improvement of health care services. It is especially vital to Shriners hospitals for crippled children in furnishing free hospital services.

As many witnesses and submissions have already noted, there is a growing consensus within the hospital community that private philanthropic giving will decline significantly when national health insurance is approved. Certainly, no current designer of a national health insurance plan seems willing to tack on to any bill the real costs of medical education, research, facility construction, equipment replacement, and other activities not directly related to personal patient care, all of which are necessary for better and less expensive treatment for covered individuals.

We believe that all present tax incentives for voluntary hospital assistance should be continued. By so doing, the private sector, rather than appropriated revenues or special taxes, will furnish the additional resources for important operational, educational, and capital needs of such voluntary hospital systems.

Finally, we seek nothing except the opportunity to serve humanity as we have done for 53 years.

We would like to establish our right to the pursuit of happiness we find in helping the crippled and burned child.

Thank you.

Mr. Rostenkowski [presiding]. Is there any comment that any witness would like to make about another witnesses' testimony?

Is there any interchange at all that you would like to engage in?

Dr. Spencer. Yes, Mr. Chairman.

Mr. Rostenkowski. Dr. Spencer.

Dr. Spencer. I would like to address this question to Dr. Peterson, who just arrived.

In your testimony you talk about the use of allied health personnel and clearly you are an expert in that area. To what extent could development and use of allied health personnel, and by that I mean physician extenders, medics, physician assistants, and nurse practitioners—first of all, affect the physical manpower requirements; and, second, the cost or potential cost of the national health insurance program?

Dr. Peterson. I think the big factor in the use of nonphysician practitioners has to do with the relief that this allows physician services now being, I think, wasted. There was a recent report in the Journal of the American Medical Association of a private practitioner up in Jamestown, N.Y., who hired six nurse practitioners, nurses who are given skills to carry out many of the diagnostic and therapeutic functions that physicians generally fulfill in office visits. And in a very brief report in the journal he states that one physician working a 40-hour week with six nurse practitioners was able to provide 21,000 office visits in a year.

That is about three times the total number of office visits given by a sole M.D. primary care practitioner. And if one adjusts those figures, it really means his productivity is that of four physicians.

Now, that in itself is, I think, often misinterpreted to mean that these so-called physician extenders or allied health personnel—I prefer to call them "nonphysician practitioners"—are a substitute for physicians. I don't think that is what I would argue for. I think that what the nonphysician practitioners provide are services that people generally don't have available to them today. They provide people who understand the human element of the psychosocial problems that most office visits represent.

They are aware of their limitations and refer to physician colleagues on the team. I think these extenders as they are called in legislation—

I think it is an unfortunate term—can really add to the dimension of health services substantially.

Now the second part of that question is a much tougher one.

Mr. ROSTENKOWSKI. Before you go to that, Doctor, these nurses, did the study show what they were paid and if they were paid, what in comparison to a doctor would we have saved in dollars?

Dr. PETERSON. I think that is precisely the equivocation I have on the second part of the question.

The study did not talk to that, but there have been studies done by the University of North Carolina School of Public Health that show that the average nurse practitioner salary in 1973 was of the order of $9,000 a year. Now I think that is a statement about the status of women even in our society, the status of nurses in the hierarchy of health professionals and should not be perpetuated under any system, current or anything we might invoke.

So I think if adjustments were made and people were more properly reimbursed for what they do, I can't really answer the question of what would be the net effect on costs. As a matter of fact, I submit as my testimony emphasizes, that the marginal differences in costs by effecting reimbursement of practitioners for services properly provided and in a proper system are probably rather small compared to what will be done if the system were made efficient and effective rather than the laissez-faire operation that obtains today.

I think the impact of using nonphysicians is enormous. I don't think it should be looked at simply on the basis of costs.

Mr. ROSTENKOWSKI. Because of this vote, Mr. Cotter will preside for a few minutes, I suggest there be an interchange if there is anything you wish to bring out that would help us in our deliberations.

Dr. SPENCER. Thank you.

Mr. COTTER [presiding]. Yes, Dr. Spencer, you may proceed.

Dr. SPENCER. I would like to address a question to Dr. Lynch.

This morning in the testimony of Dr. Vernon Astler, on page 3 of his written testimony, he states that in Great Britain an estimated 1.5 million people await hospitalization and there is up to a 2.5-year wait for elective surgery.

I wondered if Dr. Lynch could comment on that statement as to its validity or its significance or nonsignificance.

Dr. LYNCH. It really depends on what people are talking about when they talk about waiting lists. I think that some of the basic nature of what is called a waiting list was described recently by a surgeon who was invited by the minority members of this committee to speak in September of this year, Mr. Reginald Murley, a surgeon in the National Health Service.

He, while finding great fault with certain parts of the National Health Service in England, thought that this talk about waiting lists was sheer nonsense. He regarded them as basically appointment lists that they were basically people with an appointment to come into a hospital or some part of the system for some kind of an elective procedure.

A friend of mine——

Mr. COTTER. What procedure is that, just elective procedures?

Dr. LYNCH. Yes, sir. That was his explanation of it. The people that I remain in contact with in England, physicians, people in practice, are not discussing this matter of waiting lists in terms of large increases in number. One of the things that has come to the fore in England was whether or not private practice will be allowed; 2 percent of the beds in England are private beds.

There is some discussion about eliminating those private beds. These are ways in which persons who have the minimum amount of insurance for a hospital bed are able sometimes to move into hospitals more quickly than someone waiting for a procedure.

But let me tell you the other side of that. That is, an old friend of mine, a 70-year-old woman in England recently needed to have a hip prothesis inserted and I was interested in light of what someone else testified earlier to today, when they said any old person who needed a hip replacement would die in England before they got it. She was able to within 6 weeks have this operation at the university teaching hospital, which was in her local area. She insisted, however, on being operated upon by the world's leading specialist, who was written up recently in Time magazine. That is where a lot of persons go to be operated on.

She decided at her option to wait the year and a half in order to be operated on by this person, which was done freely at National Health Service cost. She, of course, would have been classified as waiting although she was on an appointment list of her own choosing.

There are none who claim in talking about the English system at the moment that people do not have access to medical care. Everybody has access to medical care through their general practitioners; 96 percent of the population, as I said, are signed up with a general practitioner.

They do get immediate care. There is no one who wants it who does not get immediate care for emergency conditions which are a threat to life.

As a practitioner in England some years ago—but at that stage the National Service was 20 years old and well established in its ways—I can state categorically there was no problem in access to general practitioners, in access to hospital and laboratory X-ray services, in access to consultants. I never at any stage had any problem getting any patient into a hospital at all nor was there a waiting list in England at that time.

A waiting list beyond what was regarded—what we regard here as a normal waiting period. There are problems in England currently. I believe no one would deny that. There are problems here, too, bound up with the economic crisis that is certainly challenging the fabric of English society, challenging their relationships between labor and management.

Health care is involved in this crisis; there is no two ways about that and it must necessarily be involved willy-nilly. But to attribute the problems in the English system at the moment to the system of health care itself rather than what is going on in society is about as fair as damning American society on the basis of experiences gained during the depression.

It is also worthwhile noting in this case, that a lot of what he said and what travels across the Atlantic as professional statements are, in fact, statements made by professional organizations, but in their capacity as a union. And professional organizations speak with two voices.

Very often there is a voice of professional practice, but also very often there is a voice that is a union, labor union, for their members. As such it is important, I think, to sift out the record of what is said.

Mr. COTTER. How about the freedom of choice of physicians?

Dr. LYNCH. Freedom of choice, there is absolute freedom of choice of your physician in England, particularly of your general practitioner, so you would move into an area, settle in England, and then look at all the physicians in that town or surrounding area and decide which of those you wish to sign up with.

Mr. COTTER. Assume I have to have surgery. Is there freedom of choice to choose your own surgeon?

Dr. LYNCH. Insofar as what is available, yes. You would be referred through your general practitioner to the consultant in the particular area or that particular hospital, the consultant that that particular physician uses. So if I were working in Nottingham and I had a patient who needed to be seen by, say, an orthopedic surgeon, there are half a dozen at the teaching hospital and I would select which one I wanted my patient to see.

Like the friend I described, she decided to go elsewhere.

Mr. COTTER. So you would have a waiting period? If you chose someone other than those half a dozen immediately available, would you have a waiting period?

Dr. LYNCH. Not necessarily. It would depend on where you were going. Say someone wished to be seen by the newest of the consultants. There may not be a waiting list. If you wish to be seen by the person who is recognized as the leader in the country, then there would be some time.

Dr. PETERSON. I would appreciate a chance to amplify what is in my testimony, but I would like to respond immediately to what you were just asking.

Mr. COTTER. I wish you would.

Dr. PETERSON. There is a lot of mythology about this freedom of choice business. People in the United States who find themselves in a neighborhood where they can identify someone to deliver their care do not have any greater freedom of choice than people who find a similar array of general practitioners of the National Health Service in England. As a matter of fact, the English probably have greater freedom of choice among general practitioners.

What I think is the mythology in this country is that once you get into what is called the nonsystem, it turns out that the choices are not made by the patient. The choices are made by the hospital affiliations of the first contact person, whether that be a gynecologist as it is in the case for women in the child-bearing years, or whether it be the pediatrician taking care of the kids. The surgeon doing the tonsillectomy is not chosen by the family. He is chosen by the physician who makes the referral.

I think the freedom of choice is highly overemphasized and if people are concerned about that, which I think they should be, then people should have options. We can design a system that allows for this. But I think this business of saying that if we give up what we have, we will be locked into something where nobody has a choice and everybody is in lockstep, I think that is a very specious argument too often introduced.

Mr. COTTER. Anyone else?

Father EHRENS. I would like to have Sister Margaret Farley share with us her ideas on the fears expressed about overutilization.

Sister MARGARET. Actually some of the other panelists have addressed those questions already and that also gets us into some areas of mythology, it seems to me, both about our present systems, National Health Service or under national health insurance.

First of all, there is no hard evidence that would lead us to conclude inevitably that utilization is going to skyrocket under national health insurance. The studies that have been done in Canada, which Dr. Spencer cited, and other studies that have been done, do show that there is a shift in utilization when a new health system is introduced. There is a shift, first of all, in patterns of utilization which so far has always taken the trend of lowered hospitalization rates and raising of use of physicians or physician's assistants and so on. In other words, medical care other than than that delivered in a hospital setting or especially in an acute care hospital setting is likely to rise, but hospitalization is lowered.

So that if costs is the question on utilization, which it usually in these discussions is, it is very misleading to talk about a rising utilization when, in fact, hospitalization is lowered and costs thereby lowered.

There are other shifts that have been noted in some studies. One is a shift in the population that uses medical care. That is, some times there is a lowering of use of medical institutions and medical providers on the part of those in upper incomes and rising utilization on the part of those in lower and middle-income groups.

Most of the studies emphasize the latter.

But that seems to make a lot of sense. One of the, not only justifications, but moral imperatives regarding a change in health care delivery systems and changing to national health insurance, or some other system than we have now, is that persons in certain income groups cannot now get that medical care. So if you make it possible for them to get it, there isn't necessarily going to be overutilization.

I wouldn't call that overutilization. That is called equitable health care delivery, which is the responsibility of society, to figure out how to take care of that. I just want to tie that in with what I said before. It doesn't necessarily mean that costs will skyrocket so the society suddenly becomes incapable of providing necessary care.

I think, also, you know, there are other ways of considering control of utilization such as medical education. That is something that doesn't get talked about a great deal, but there is a dearth of opportunity of that in our country. The more people who know about their own health, the less likely they are to seek health care for unnecessary reasons; that is, for what sometimes is called trivial reasons.

It is because of ignorance that people fear symptoms that they have; because they don't know much about their own health. As a result, they are inclined to seek trivial health care.

So it seems to me some funding of medical education and some sense of responsibility on the part of the medical profession to give more attention to education of persons generally regarding health is a way of dealing with what might be part of a problem of overutilization.

Someone else might want to comment on that, because it is something that has appeared in a lot of the testimony, but this touches on a lot of different things. I wanted to say something to Mr. Thornton's testimony, too.

I, too, have some concern for voluntary health care systems, but I also have some worries about how that would be provided for under national health insurance.

It is possible, it seems to me, to place some arguments for voluntary health care systems or free health care which has something to do with questions of overutilization, or questions of society deciding whether some forms of health care are beyond the capability of the society in providing. For example, some kinds of burn units would fall into that category.

Some of the concerns that Congress has had after decisions that have already been made about kidney dialysis and so on would be in that category. It seems to me there are places for other forms of providing health care—that much falls in a category other than what could be defined as moral minimum; that is what needs to be provided for all persons.

A voluntary health care system might address itself to those categories. But my worry is that arguments will be offered and I don't think you were offering them in this regard, but I have heard them offered in other forums, that that would perpetuate voluntary health care systems which in fact will only serve to perpetuate a separate system which then will only serve the rich or serve the affluent.

That has happened to some extent in some countries. I fear it happening now, and I fear especially religious-affiliated institutions getting trapped into something like that.

Mr. THORNTON. May I say in response to that——

Mr. ROSTENKOWSKI [presiding]. Mr. Thornton, may I suggest you make it brief? We are going to conclude the testimony.

Mr. THORNTON. I surely will.

On the contrary, rather than serving the affluent, our hospitals serve only the medically indigent, those who cannot pay at all. About one-third of our patients are minority patients, but if the family of the patient can pay, that patient is not eligible to be admitted to our hospital.

Sister MARGARET. Which, as you say, would mean you would have a different population given national health insurance if it were a matter of providing care for those that couldn't afford it.

Mr. THORNTON. We realize by definition there may be no more medically indigent children. However, in addition to that, we are able to provide and are providing a service in the burns treatment as you alluded to them, which is not matched in any other hospital or medical care system.

We are of a feeling that our Boston, Galveston, and Cincinnati burns units are benefiting humanity worldwide, which benefit would not have been provided had the units not been in operation.

Mr. ROSTENKOWSKI. Reverend Miller, you alluded to multiplicity in regulations and standards. Do you have any suggestions as to what we could do through legislation in this area?

Reverend MILLER. I regret very much that I am not an expert in the health care field. I was bringing here Dr. Christison's remarks on this and I would be glad to have him submit an answer.

Mr. ROSTENKOWSKI. If he will submit that for the record, then the record will remain open for several weeks.

[The information follows:]

SUPPLEMENTARY STATEMENT TO AMERICAN BAPTIST TESTIMONY BY JAMES A. CHRISTISON, EXECUTIVE SECRETARY

Reverend Elizabeth Miller represented American Baptist Churches during the Committee hearings on National Health Insurance. During her testimony she submitted comments on my behalf concerning the health situation in the United States. It has been brought to my attention that the Committee requested additional comments with respect to my concern about "the multiplicity in regulations and standards."

Each state has its own set of statutes and regulations dealing with the licensing of facilities and personnel in health care delivery. In addition, almost every political subdivision within the state has its own set of regulations which take the form of zoning laws, fire regulations, building structural regulations, etc. On top of all of that Medicare has established its own regulations in approving facilities that would be eligible for receiving Medicare payments on behalf of patients. None of these regulations by themselves are necessarily bad. But they do create two basic problems for organizations like our own that are attempting to participate in providing health care to persons in need throughout the United States.

The first problem is that with all of these regulatory bodies acting independently the cost of providing facilities and trained personnel is substantially increased. These increases are either passed along to the patient or resident or else the voluntary organization is forced to discontinue providing services. There are many illustrations of this problem but one that comes to mind has to do with one of our American Baptist facilities in Florida. I have not recently researched into this particular illustration, but I believe my memory is reasonably accurate.

One of our retirement centers in Florida operates a nursing home on the second floor level in a high-rise building. In order to assure the safety of the patients one regulatory body insisted that there be a separate outside stairway directly to the nursing home. This was a perfectly legitimate request in light of the possibility of fire and the evacuation of the patients. However another regulatory agency, who was equally concerned about the safety of the patients, had established a regulation dealing with high-rise buildings which required modification of the elevator system in order to assure evacuation of the patients in the event of a fire. This particular regulatory agency had not considered the possibility of an outside staircase as one solution. The bureaucrats who administered the regulation were powerless to approve the nursing home without an elevator modification. The result is that the same intention was implemented twice.

The other problem which can also be documented is that maintaining records and complying with all of the regulations costs a lot of money. A change in a fire regulation can require the installation of a fire door. Medicare regulations may also require a fire door but at a different location. The hospital's administrator then has to negotiate between the two regulatory agencies in order to comply with the regulations. In the meantime, Medicare accreditation may be held up and the hospital might be faced with fines for not complying with the fire regulations.

Many of us believe that there should be a uniform code dealing with regulations and licensing procedures for facilities and personnel in any building designated as a health care delivery facility. Exceptions to the uniform code would be subjected to arbitration if they could not be negotiated between the parties involved. No regulatory agency could change the uniform code unilaterally. Every health care facility would be subjected to periodic examinations by a single team of examiners that would deterimine compliance with the uniform code. Federal, state and local regulatory agencies would accept the single examination for purposes of granting building permits, certificates of need, accreditation, etc.

Health insurance is desperately needed in this country but there are other systemic problems in the health care delivery system which must also be corrected. A comprehensive health care insurance bill should attempt to deal with some of these other problems. Now is the time to spend the money and do the investigation that is necessary to improve the health system in the United States.

Mr. Rostenkowski. I want to thank this panel, and apologize for the interruptions, but we are putting the ceiling on our budget today, and we could not miss that.

Thank you very much for joining us today.

The committee stands in recess until 9 o'clock tomorrow morning.

[Whereupon, at 4:21 p.m., the subcommittee adjourned, to reconvene at 9 a.m., Thursday, November 13, 1975.]

NATIONAL HEALTH INSURANCE

THURSDAY, NOVEMBER 13, 1975

U.S. House of Representatives,
Subcommittee on Health,
Committee on Ways and Means,
Washington, D.C.

The subcommittee met at 9 a.m., pursuant to notice, in the committee hearing room, Longworth House Office Building, Hon. Dan Rostenkowski (chairman of the subcommittee) presiding.

Mr. Rostenkowski. The committee will come to order.

We welcome you all this morning and express our appreciation for you coming to participate in this panel discussion. I know some of you have already been with us before the Ways and Means Committee, but for those who have not, what we do is open the panel for discussion after all of the testimony has been given and encourage interchange between the panelists. After that we begin to question, if there are any questions.

So, Mr. Gaddy please identify your organization and proceed.

PANEL CONSISTING OF DR. C. WELTON GADDY, DIRECTOR, CHRISTIAN CITIZENSHIP DEVELOPMENT, CHRISTIAN LIFE COMMISSION OF THE SOUTHERN BAPTIST CONVENTION; J. ROY ROWLAND, JR., M.D., CHAIRMAN, COMMITTEE ON NATIONAL TRENDS, RAMIFICATIONS AND ORIGINS OF LEGISLATION; DAVID G. CRANE, M.D., BLOOMINGTON, IND.; ROBERT M. SADE, M.D., CHARLESTON, S.C.; AND REV. JOHN W. LIPPHARDT, MEMBER, WEST VIRGINIA ANNUAL CONFERENCE BOARD OF CHURCH AND SOCIETY

Dr. Gaddy. Thank you, Mr. Chairman. Thank you for this opportunity to appear.

My name is Welton Gaddy. I serve as director of Christian citizenship development on the staff of the Christian Life Commission of the Southern Baptist Convention. My address is 460 James Robertson Parkway, Nashville, Tenn.

According to the polity of the Southern Baptist Convention no Southern Baptist can ever speak for the entire denomination or even for another Southern Baptist. Thus I speak for myself alone. However, my remarks have been formulated with sensitivity to the concerns of Southern Baptists generally; as a Southern Baptist graduate of a Baptist university and a Southern Baptist theological seminary and as a minister presently serving with the Southern Baptist agency most directly concerned with the social issue of health.

The purpose of my testimony is twofold: First, to request that you support the enactment of some significant program of national health security; and, second, to elaborate some of the moral principles which we believe should inform, guide, and judge the decisionmaking process out of which such a program will come.

The product of present discussions on national health security should be the implementation of sound moral principles—not a reaction to the wishes of the most vociferous lobbyists or a concession to the economic concerns of one special-interest group.

Here then is a brief statement of some of the major moral principles which weigh most heavily upon your current deliberations. I verbalize these ethical insights before you with a plea that you give them careful consideration as you do your important work.

Both the documents of democracy and the Bible affirm the worth of every individual—the dignity of personhood and the right of every person to experience the fullness of life. Implicit in these materials and this fundamental Bible doctrine is the concept of health care as a moral right.

Personal worth is a moral principle which points up the need for a national program of health security which makes comprehensive health care available to all who need it when they need it.

Health is not the concern of individuals alone, doctors or patients. All of society shares responsibility for health care.

A just society gives priority to persons. Social organizations and social institutions exist for people, and not vice versa. When a society tolerates health services which are poorly distributed, facilities which are inadequate, administration which is not accountable, and costs that are exorbitant, it is time for a change in the Nation's health care system.

A just society protects the freedom of all of its members. Both those in need of health care, a category which embraces all of us, and those who provide health care, professionals and paraprofessionals, have legitimate freedom concerns which merit careful attention.

A just society supports equality. The equality embraced by justice is the equality envisioned in the doctrines of creation and redemption within the Christian and in the "self-evident truths" within the philosophy of our form of government.

When the measure of a person's money determines whether or not that person receives adequate health care, equality is mocked. When there is a concentration of medical staff and facilities among the affluent and a critical shortage among the poor, equality is not a reality. When so much time, money, and personnel are devoted to crisis medicine that those needing the routine requirements of good health care have to wait, equality is denied.

Social justice is a moral principle which points up the need for a national program of health security which makes comprehensive health care available to all who need when they need it.

Government, Christians have always believed, is a morally responsible institution. Reciprocal moral responsibilities exist, moreover, between citizens and the government of which they are a part.

Government has a moral responsibility to correct the abuses and the inequities of the present health care system and to develop a better system. If we do have the knowledge, wealth, and ability to assure every American the health care needed without financial ruin, then we have a moral responsibility to be on with that task. Long overdue is the day when we will deal with basic human needs in terms of a morally responsible system of health care.

Governmental responsibility is a moral principle which points up the need for a national program of health security which makes comprehensive health care available to all who need it when they need it.

In conclusion, let me reiterate the importance of moral values and ideals in your deliberations. The nature of the health care program which you finally legislate should reflect not only an attentiveness to the expertise of medical professionals and to the needs of the Nation's citizens, but also a commitment to fundamental moral precepts. This will produce a comprehensive program of national health security with universal coverage, real accessibility, careful planning, and adequate financing which will be administered with both compassion and accountability. Please know of our continued interest and high expectations regarding your work.

We request from you and the national Congress a morally responsible program of national health security.

[The prepared statement follows:]

STATEMENT OF C. WELTON GADDY, DIRECTOR OF CHRISTIAN CITIZENSHIP DEVELOPMENT, CHRISTIAN LIFE COMMISSION, SOUTHERN BAPTIST CONVENTION

INTRODUCTION

Thank you for the opportunity to appear before this important Subcommittee of the distinguished Committee on Ways and Means. My name is Welton Gaddy. I serve as Director of Christian Citizenship Development on the staff of the Christian Life Commission of the Southern Baptist Convention. According to the polity of the Southern Baptist Convention, no Southern Baptist can ever speak for the entire denomination or even for another Southern Baptist. Thus, I speak for myself alone. However, my remarks have been formulated with sensitivity to the concerns of Southern Baptists generally; as a Southern Baptist graduate of a Baptist University and a Southern Baptist Theological Seminary and as a minister presently serving with the Southern Baptist Agency most directly concerned with the social issue of health.

The Christian Life Commission is the one agency in our twelve-and-one-half-million member national convention which is specifically instructed to address itself to issues of social ethics. The program assignment of the Christian Life Commission focuses upon the moral dimensions of family life, economics and daily work, race relations, citizenship, and a host of other special ethical concerns. Interest and involvement in discussions of health care legislation are consistent with a broad concern for all social issues which affect the quality of people's lives. Motivation for both a general social consciousness and for involvement in specific social issues, such as this one, resides in the Judeo-Christian ethic.

STATEMENT OF PURPOSE

The purpose of my testimony is twofold: (1) First, to request that you support the enactment of some significant program of national health security; and (2) Second, to elaborate some of the moral principles which we believe should inform, guide, and judge the decision-making process out of which such a program will come. I do not come to argue the merits of one specific piece of health-care legislation over another or to advocate the enactment of one particular plan of health care *per se*. My expertise is not that of an economist, a medic, or a political scientist. I am a minister with a graduate degree designed to enable me to speak to the ethical foundation on which and the ethical framework around which a structure of national health security may properly be erected.

The prevalence of certain disturbing questions and conflicting opinions threatens to impose upon us an invalid order of priorities related to national health security. Excited outbursts of "how much will it cost?" "who will pay for it?" and "who will benefit most from it?" are cases in point. Far more basic are inquiries regarding the moral dimensions of the need for a new policy of national health security and the ethical guidelines which should be heeded as this policy is developed.

There now seems to be a consensus that the present system of health care is inadequate and in need of change. If true, that consensus is a moral development worthy of applause. However, change for change's sake has no inherent worth. The product of present discussions on national health security should be the implementation of sound moral principles—not a reaction to the wishes of the most vociferous lobbyists or a concession to the economic concerns of one special-interest group. Thus, a consideration of pertinent theological truths and moral principles can be an important aspect of this committee's work.

Though the opinions of Southern Baptists in the nearly thirty-five thousand churches of the Southern Baptist Convention would no doubt reflect a cross section of the nation's sentiments regarding specific health care proposals, most would agree that any system of national health security should be established on firm moral principles. Members of the Christian Life Commission meeting September 17, 1975 voted unanimously to support "the enactment of a morally responsible program of national health security" and requested staff members of the Christian Life Commission to communicate this position to appropriate persons in the Congress.

Here then is a brief statement of some of the major moral principles which weigh most heavily upon your current deliberations. I verbalize these ethical insights before you with a plea that you give them careful consideration as you do your important work.

MORAL PRINCIPLES AND HEALTH CARE

Personal worth

Both the documents of democracy and the Bible affirm the worth of every individual—the dignity of personhood and the right of every person to experience the fullness of life. Implicit in these materials and this fundamental Bible doctrine is the concept of health care as a moral right.

The spiritual community of the Judeo-Christian faith worships a God who has consistently revealed his desire for people to be whole—mentally, physically, spiritually, and socially. The Bible underscores the importance of healing ministries and encourages the giving of aid to those who suffer. Jesus Christ announced as one of the purposes of his ministry "that they might have life and have it abundantly" (John 10:10) and then demonstrated his personal commitment to the healing task. The people of God have been charged with a compassion for all who suffer and are commissioned to function as a healing community.

The political community which brought into existence the United States of America declared from the very beginning that all people are endowed by their Creator with the "unalienable rights of Life, Liberty, and the pursuit of Happiness." The right to life embraces the right to health, without which life is in jeopardy. Health is an essential ingredient in the "domestic tranquility" and "general welfare" in support of which this nation was founded and its Constitution written.

Health care is a right. Health is, in some respects, the gift of God; but health care in our society is a moral right. Every person should be able to draw upon the resources of both a preventive and corrective health care system according to personal need.

For Christians, life is not the ultimate value in personhood. There are some things worth dying for. However, life is a gift from God which is to be respected, protected, enriched, and ultilized with moral responsibility. Anything which destroys life, either by sudden extinction or slow deterioration, should be questioned critically and eliminated when possible. Any system which discriminates between persons in the quality of health it makes available to them should be challenged and eradicated. Every person, created in God's image, has a right to experience life with wholeness and health, to the limit of our abilities to provide them.

In our reasonably affluent society, no person should have to suffer the trauma of deciding whether or not a family member is sick enough to justify spending money on health care which is needed for minimal food, housing, or clothing needs. No person should have to bear the double burden of a critical illness which must be dealt with and the anxiety of whether or not the illness or the cure can be afforded. No person should be set aside on the cot of an emergency room while his or her physical fate is debated in terms of money. It is not morally right for health care to be viewed as a marketable commodity owned entirely by skilled professionals and as purchasable only when the price is right among bargaining consumers who are sick.

Obviously, all sickness cannot be eradicated and all pain eliminated. The Christian faith recognizes this truth and functions as a resource for enduring sickness, bearing pain, and facing death. However, for persons to suffer and die when their illnesses could have been prevented and their deaths avoided is for moral judgment to be pronounced upon us all.

Personal worth is a moral principle which points up the need for a national program of health security which makes comprehensive health care available to all who need it when they need it.

Social justice

Increasingly we are aware of the basic truth of the Bible that "one of us lives to himself, and none of us dies to himself" (Romans 14:7). We are becoming more appreciative of the profundity of John Donne's classic statement that "no man is an island." With greater clarity we see the wisdom of the biblical admonition, "Bear one another's burdens" (Galatians 6:2). At the time of a national celebration of the blessings of independence, we are confronted by the sobering realization and responsibilities of interdependence—intranationally and internationally. The illness of one person inevitably affects others. Sickess in one segment of society soon begins to affect the quality of life in other segments of that society. Health is not the concern of individuals alone, doctors or patients. All of society shares responsibility for health care.

Our democratic social system has chosen justice, a basic moral precept, as its minimal standard of behavior. From the Bible we learn of the importance of justice as Amos cries, "Let justice roll down like waters, and righteousness like an ever-flowing stream" (Amos 5:24). Today, the actual content of justice involves the priority of persons, the protection of freedom, and the support of equality.

A just society gives priority to persons. Social organizations and social institutions exist for people and not vice versa. Thus, every system and structure of society should be evaluated by its effect on the people involved—what is done for them and to them. When a social program ceases to benefit the very people who most need its benefits, that program should be reevaluated and reformed or terminated. More to the point of our common concern here, when a society tolerates health services which are poorly distributed, facilities which are inadequate, administration which is not accountable, and costs that are exorbitant, it is time for a change in the nation's health care system.

A just society protects the freedom of all of its members. Both those in need of health care, a category which embraces all of us, and those who provide health care, professionals and para-professionals, have legitimate freedom concerns which merit careful attention. The concept of freedom of choice is a morally defensible concept; and options as to the type and method of medical care should therefore be continued. Those who wish to receive preventive or correctional health care by means of a private medical practice should be at liberty to do so. At the same time, those who, because of an inability to pay, are currently cut off from comprehensive health care should be free to receive treatment. A person condemned to illness is not free. The society in which that person lives is not free.

A just society supports equality. Though there are obvious, actual inequalities among people, the equality embraced by justice is one which transcends these. This is the equality envisioned in the doctrines of creation and redemption within the Christian faith and in the "self-evident truths" within the philosophy of our form of government.

When the measure of a person's money determines whether or not that person receives adequate health care, equality is mocked. When there is a concentration of medical staff and facilities among the affluent and a critical shortage among the poor, equality is not a reality. When so much time, money, and personnel are devoted to crisis medicine that those needing the routine requirements of good health care have to wait, equality is denied.

Social justice is a moral principle which points up the need for a national program of health security which makes comprehensive health care available to all who need it when they need it.

Governmental responsibility

Government, Christians have always believed, is a morally responsible institution. Reciprocal moral responsibilities exist, moreover, between citizens and the government of which they are a part.

The Bible teaches that government is an institution willed by God (Romans 13:1–2). Those who function as leaders of government are described by the Apostle Paul as God's servants (Romans 13:4). This lofty view of civil authority is complemented, however, by a vision of government's moral responsibilities for, like individuals, government has moral duties to perform. The author of Proverbs makes the point concisely, "Righteousness exalts a nation, but sin is a reproach to any people" (Proverbs 14:34).

Place in juxtaposition to this theological-ethical orientation to government the disturbing statistics regarding health care delivery within our government. The result is a moral imperative to effect change. You know the data far better than I do. When a nation with the capability of providing the best health care services in the world finds its status among developed nations regarding infant death rates and life expectancy lower than it was a generation ago, there is cause for alarm. (The *1974 Demographic Year Book* from the United Nations Statistical Office contains a great deal of information from the World Health Organization which indicates that the health of Americans compares unfavorably with that of people in other modern nations.) There is also reason to act.

Government has a moral responsibility to correct the abuses and inequities of the present health care system and to develop a better system. If we do have the knowledge, wealth, and ability to assure every American the health care needed without financial ruin, then we have a moral responsibility to be on with that task. Long overdue is the day when we will deal with basic human needs in terms of a morally responsible system of health care. Words of gratitude as well as of encouragement and challenge are due to your committee for providing a government forum in which the issue can be discussed and for providing some hope that we are approaching a better day in the health care of all the people of this nation.

Governmental responsibility is a moral principle which points up the need for a national program of health security which makes comprehensive health care available to all who need it when they need it.

CONCLUSION

In conclusion, let me reiterate the importance of moral values and ideals in your deliberations. The nature of the health care program which you finally legislate should reflect not only an attentiveness to the expertise of medical professionals and to the needs of the nation's citizens but also a commitment to fundamental moral precepts. This will produce a comprehensive program of national health security with universal coverage, real accessibility, careful planning, and adequate financing which will be administered both with compassion and accountability. Please know of our continued interest and high expectations regarding your work. We request from you and the national Congress a morally responsible program of national health security.

Mr. ROSTENKOWSKI. Thank you, Doctor.

Is Reverend Bowyer or Dr. Sade in the committee room?

[No response.]

Mr. ROSTENKOWSKI. Dr. Crane.

STATEMENT OF DAVID G. CRANE, M.D., BLOOMINGTON, IND.

Dr. CRANE. Thank you for the opportunity of appearing before your subcommittee. I know you have heard many of the charges and rebuttal remarks about a national health insurance program and I am sure some of my remarks will seem redundant, but I feel compelled to illustrate them as follows:

Our private medical care system has been under attack for many years. The intensity of this attack has been more marked during the last decade when cries of a health care crisis have been heard from many corners.

A common accusation by those who complain of this alleged health care crisis is that the health of this country is well below what it should be because of inadequacies in our medical system. To support this argument, critics repeatedly drag out the same international statistics which allegedly show our Nation as being way down the list, as evidenced by such things as infant mortality and life expectancy.

I hesitate to even address myself to these wornout allegations, but realizing that they will again be brought up, I would simply like to remind this committee that in regard to infant mortality tables, the very book from which these statistics are drawn, points out that comparisons cannot validly be made, one nation with another, because the criteria for tabulating these statistics vary so remarkably. It might better be pointed out that at the turn of this century our infant mortality was 125 deaths per 1,000 births and is now down to 18.5 deaths per 1,000 births.

The other much traveled statistic is to compare lifespans of persons living in this country with those of other nations. For example, Sweden is often contrasted with the United States. It is alleged that Sweden's socialized medical program accounts a large degree for their increased longevity.

A statistic not often cited is the fact that Swedes living in Minnesota actually live longer than their relatives still living in Sweden. It is also rarely explained that Sweden has a very homogeneous population and society, as contrasted with this country.

As New York Times editorial writer Harry Schwartz pointed out, "Whatever its sins, the American medical establishment is not responsible for hunger in this country, or the automobiles that kill 50,000 or more people here annually, or the drug overdoses that claim thousands of young lives, or for the millions of Americans who court heart disease and lung cancer by overeating, exercising little or not at all, and smoking a pack or more of cigarettes daily." The allegations arising from international statistics simply don't hold water.

Before we ever seriously consider a national health insurance program, we should take a careful look at countries who have already implemented such programs. Great Britain is perhaps the classic example. One of the best ways to view the effectiveness of such a system is to see how members of that system react to it.

British doctors are given examinations in London in order to qualify them to practice in the United States. In 1972, 404 doctors took the test; in 1973, 828; in 1974, 1,019; and in January of 1975, 2,517 with a comparable number taking examinations in July of this same year.

If government medical care is as good as so many suggest, why are British doctors fleeing to the shores of this country? Not only are the doctors leaving the British system, but the costs of delivering free health care is now 30 times greater in Great Britain than it was at the time the National Health Service began.

A leader of the Marxist wing of the Labor Party in England. Anthony Wedgewood Benn. has called for the abolition of all private beds in the National Health System in Great Britain. But when his small son required surgery. the boy was admitted secretly under Mrs. Benn's maiden name as a private patient. It finally gets down to what is good for the goose is not good for the gander.

A previous witness before this subcommittee alluded to the millions of Americans who were being unserved in rural America and the inner cities because of a lack of doctors. If we take a closer look at the actualities. we find that out of 3,084 counties in our Nation only 132 are doctorless. Greater than 255 percent of these 132 counties have physicians available within a 15-minute drive. Only 0.2 percent of the entire population even reside in these 132 counties.

In regard to the charge about a maldistribution of doctors in the inner city. a 1968 study on the subject revealed evidence to the contrary. For example. Boston had the same ratio of physicians to patients in the inner city as it did in the suburbs.

I interned at Cook County Hospital and one of my colleagues set up practice in the inner city of Chicago. After 4 years. this black physician fled to the suburbs and told me that the risks were just too great for him to remain in the city proper. He said his office was broken into on several occasions. presumably by persons in pursuit of drugs. and he said his physical person had been placed in jeopardy on several occasions. He fled the inner city for the same reason many businessmen do. It simply wasn't safe.

This is not a medical problem. but a social one. On the statistical tables his departure will be recorded as part of the maldistribution. when. in fact. it was really a matter of survival.

Another common charge leveled at the medical community is one of astronomically increased doctors' fees and hospital charges. Department of Labor statistics revealed an annual increase of 3.7 percent in doctors' fees between 1956 and 1968. while incomes of the average worker were going up at an average annual rate of 4.2 percent. To be sure there have been significant increases since that time. but most of those increases were due to wage and price controls kept on the medical community long after everyone else was unshackled.

The charge about dramatic increases in hospital costs have very little to do with the actual delivery of health care. In reality. 65 percent of hospital budgets goes toward payment of employee salaries. Because the unions have aggressively organized hospital staffs during recent years. the salaries have increased dramatically with the hospitals subsequently having to absorb the bill. Inflation is another dramatic reason for increased hospital costs.

Another very significant reason for the increased cost is one too often ignored. This consists of new. lifesaving equipment and techniques that have been developed over recent years. Interestingly. the medical profession is condemned for its poor delivery of quality care and yet the advancements of medicine are then condemned because they increase the costs of medical care.

A problem that has surfaced in virtually every country with a national health program has been one of overutilization. We find this true even with our own medicare system. In countries like Great

Britain, Germany, France, and Sweden the average length of a hospital stay is almost twice that of our own country. The cost for delivery of this kind of medical care obviously begins to skyrocket.

The cost of an average outpatient visit to a private physician in the United States is just about one-fifth the cost of a comparable visit at a Veterans' Administration hospital. This is simply a reflection of the lack of efficiency when Government takes control. Within this last month the General Accounting Office said that it costs $12.39 to process a single medicare bill through the Social Security Administration's Division of Direct Reimbursement. The average cost of processing the same sort of bill is $7.31 by the Travelers Insurance Group; $7.28 by Mutual of Omaha; $3.81 by the Chicago Blue Cross; and $3.55 by Maryland Blue Cross. This is something we all inherently know, but tend to gloss over with our good intentions and compassion for the sick. To be sure, every physician in this country would like to deliver the best medical care possible to each individual American. It is just that free medical care will be abused.

According to recent statistics from the U.S. Department of Labor, hospital room charges have gone up on the average of 9 percent per year from 1970 through 1975, and physicians' fees have increased slightly better than 6 percent per year during that same period of time. These increases aren't even keeping up with double-digit inflation. The U.S. Department of Commerce revealed that the average American spends almost twice as much on the cost, care, and maintenance of his automobile as he does for his health care. This, however, doesn't seem to elicit the same hue and cry for Government controls of the auto industry, although such a demand may not be too far off.

Another common allegation is our insufficient number of physicians. Yet if we compare ourselves with the Common Market countries, we find their ratio, as of 2 years ago, was 670 : 1. At that time ours was 600 : 1, and today it has been reduced to 590 : 1. Along with this, we are continuing to produce physicians at a rate three times that of our population increase. In fact, our medical crisis may be a problem of having too many doctors in the not too far distant future. The charge of our producing too few doctors simply doesn't stand up.

There is another area involving any prospective national health insurance bill that is of remarkable significance. I happen to also be an attorney as well as a medical doctor and that is why this area touches me very closely. This has to do with the formerly sacred and confidential doctor-patient relationship.

Included in the Social Security Act of 1972 [Public Law 92–603] there is a provision dealing with professional standards review organizations. While the declared purpose of this provision is to "promote the effective, efficient, and economic delivery of health care services of proper quality," the law not only lends itself to a rationing of health care in cookbook fashion, but perhaps more importantly, allows for an invasion of the confidential relationship between doctor and patient. If national health insurance were to become a reality, every recipient of medical care under that program would be vulnerable to having his records available to the Federal bureaucracy.

We, private practicing physicians, were told in a brochure sent out by HEW that any data or information collected by a PSRO would be held in strict confidence since the PSRO legislation contained "strong penalties for breaches of confidentiality by any reviewer or employee." A careful review of the actual wording of the law proves to the contrary.

Section 1166(a) reads as follows:

> Any data or information acquired by any professional standards review organization, in the exercise of its duties and functions, shall be held in confidence and shall not be disclosed to any person except: (1) to the extent that may be necessary to carry out the purposes of this part or (2) in such cases or under such circumstances as the Secretary shall by regulations provide to assure adequate protection of the rights and interests of the patients, health care practitioners, or providers of health care.

These exceptions as defined by the law leave the Secretary of HEW in a position to invade private medical records at his own discretion. During recent years we have become acutely aware of how bureaucratic power can be abused. Officials at the IRS, FBI, GSA, and the Federal Reserve Board's new electronic funds transfer system will easily be able to penetrate the data banks of the PSRO.

The former right of privacy, one time held sacred in medical relationships, can now be violated without benefit of a search warrant, court order, or even authority of the patient. While we were assured that stiff penalties would be imposed for any violation of this sacred relationship, a maximum of $1,000 and/or 6 months in prison is all the Government imposes, and that occurs only upon conviction.

In the State of Indiana this constitutes merely a misdemeanor. Recognizing how slowly the wheels of justice seem to be operating of late, this strong penalty is, for all practical purposes, no penalty at all.

In summary, I would like to suggest that, first of all, we simply do not have a medical crisis in this country. Second, the present, highly pluralistic delivery of medical care is not only efficient and effective, but also one which delivers the highest quality of care. Third, with the invasion of Government into the funding of health care, we have seen an abuse and violation of the privacy of the individual. Americans are becoming increasingly aware of Government data banks and the continued erosion into their personal lives.

Last, I would like to suggest that American medicine still has a great deal of room for improvement. At the same time, based on past government performance, it is clear that major bureaucratic interventions will not only increase the cost of medical care in this country, but provide less satisfaction and a decrease in quality of treatment for millions of Americans.

I might only add a brief note on the lighter side. Many of you may have seen a bumper sticker that is now becoming very popular. It says, "If you are satisfied with our U.S. Postal Service, you will love national health insurance."

I thank you for the opportunity to testify before your committee.

Mr. Rostenkowski. Thank you, Dr. Crane.

Dr. Rowland?

STATEMENT OF J. ROY ROWLAND, JR., M.D.

Dr. Rowland. I thank this committee for allowing me to express my views, which are also the views of many of my colleagues.

I am J. Roy Rowland, Jr., a family physician from Dublin, Ga. I am a member of the American Academy of Family Physicians and a diplomate of the American Board of Family Practice. I am engaged in the private practice of medicine in a five-man group of family physicians. I have been in private practice since 1954.

Until recently most of my time and talents have been devoted to the care of my patients and to my continuing education. Now, however, I find I must involve myself not only in treating the illnesses and injuries of my patients, but also in attempting to protect them from a premalignant proposal called national health insurance, being fomented by socialist theoreticians or other persons who, in my opinion, frequently can't visualize the consequences of what they are doing.

In a great many areas in our country the family physician delivers the majority of medical care to the American people. Since there is now a trend toward specialization in family practice among medical students, there will be an increasing number of people receiving care from this type physician. The quality of care rendered has continued to improve.

The American Academy of Family Physicians requires a specified amount of postgraduate study every 3 years. Within the past 5 years the American Board of Family Practice, with its rigid examination, has also contributed to improvement.

Over 90 percent of the ills of the American people can successfully be treated by these physicians. Furthermore, family physicians would be found more frequently in rural areas. Now let's take a look at what the relationship of the family physician and the patient could be under national health insurance based on experience thus far in similar type programs.

What we are concerned about is the quality of and access to care at the lowest possible cost. Since the controlling factor of fee for service would be substantially reduced or removed, there can be expected an increased request for services. People will be paying for medical services through payroll deductions or whatever methods, probably on a mandatory basis, and many will seek reasons to see a physician even if no significant illness exists. It is human nature for a person to seek some return for money that he has been forced to spend. His response will be completely different in this circumstance than if he had purchased the insurance on a voluntary basis.

I can tell you from the experience that I have had with medicare and medicaid that this will cause a substantial increase in the number of office visits for trivial complaints. The physician has no way of knowing if a patient needs medical care or not until after he spends some time examining him. This will allow less time for people who do need medical care.

When the physician finds himself overloaded and rushed, he begins to treat symptoms rather than look for the cause of diseases. The physician becomes frustrated with himself, the patient becomes angry with the physician, the doctor-patient relationship suffers, and an atmosphere of hostility develops to the detriment of everyone. What happened in Laurens County, Ga., in a 10-year period from 1960 to 1970 depicts exactly what I am saying.

In 1960 the population of this country was approximately 33,000 and there were 10 physicians there. In 1970 the population was still about 33,000, but now there was 20 physicians there. In 1960 patients had little difficulty in obtaining the services of a physician. In 1970 it had become increasingly difficult to secure the services of a physician.

The increased affluence of the population and the increase in technical knowledge would, of course, cause some increase in requests for services. It would seem, however, that a doubling of the number of physicians for the same population would have been more than adequate to care for these factors. But that wasn't so.

In 1967 medicare was implemented in Georgia and in 1968 medicaid was implemented. Many of the patients in these programs presented themselves in physicians' offices for problems they would not have come in for if it were not now free, unwittingly causing a serious problem of patient overload.

If we have national health insurance, and if history repeats itself as it always does, when problems develop, the Government will step in with more money and more bureaucracy, which again will only compound the problem as it always has in the past.

With regard to hospitalization under similarly funded programs, and again I speak from experience, there will be people who demand hospitalization when it is not justified or justification may be marginal. These people will claim hospitalization is their right. This again could displace patients who need hospitalization.

Family physicians will find themselves additionally burdened attempting to comply with professional standard review organizations and various Federal regulations, using time that should be spent improving professional skills instead of for this activity. It is evident from this that the quality of care will be reduced and access to care will be more difficult. And since governmental agencies will be involved, the cost can only escalate.

The epitome of what we can eventually expect is happening in England this year. Quoting an Essex doctor in "Pulse," a British medical journal, "In 1948 GP's made the greatest error of all times. The mistake has cost the family doctor dear. Politicians have promised unlimited medical care for all. This can demand the very life, literally, of a member of the professions."

Dr. David Owen, Minister of Health, stated that the National Health Service could no longer claim to provide a comprehensive service. He told a conference of community health councils, "The health service is a rationed service. There will never be a government or country that has enough resources to meet all the demands any nation will make on a National Health Service * * *."

Physicians in countries with socialized medicine such as England find themselves seeing as many as 100 patients daily. There is no possible way that a family physician can give any type of adequate medical care under such circumstances. Large numbers of physicians have migrated from England because of the frustrations of trying to function in this type of system. National health insurance, no matter what form it takes now, will no doubt eventually lead to total socialization of medical care.

Reasons espoused for needing national health insurance are based on false premises, such as (1) a crisis in health care exists, (2) there is a public outcry for a change in our health care system, or (3) that physicians' fees have increased much more than the cost of living in general. It is inconceivable to me and my colleagues that our government could perpetrate this type of legislation on the citizens of this country who still enjoy the best health care system in the world at the most reasonable cost and which is also the most accessible—all this in spite of the fact that governmental involvement already exerts a considerable amount of oppression.

The relationship of the physician and patient would become totally impersonal under nationalized medical care. There are so many illnesses that have a phychogenic overlay which require a very intimate and trusting relationship between physician and patient. This would be lost.

National health insurance will herald the onset of the collapse of the medical care system that we now have, and the beginning of the end of the family physician in America.

Mr. ROSTENKOWSKI. Thank you, Doctor.

It is my understanding that Rev. Bowyer will not be here and, Mr. Lipphardt, you will present his testimony?

Reverend LIPPHARDT. That is correct.

Mr. ROSTENKOWSKI. You are recognized. You may proceed.

STATEMENT OF REV. JOHN W. LIPPHARDT

Reverend LIPPHARDT. Mr. Chairman, I am John W. Lipphardt, a United Methodist minister and a member of the West Virginia Annual Conference Board of Church and Society. I am speaking in behalf of our board of church and society which is grateful for this opportunity.

It is becoming increasingly more evident to West Virginians and to all Americans that our health care system is in need of improvement. Instead of reciting statistics with regard to high cost, unavailability, and waste, with which you are no doubt aware—though I have appended a few statistics to the end of this testimony—I wish to speak with regard to a statement of principles adopted by the General Conference of the United Methodist Church in the United States in April 1972. Our West Virginia Conference Board of Church and Society stands behind these principles and urges the passage of a national health insurance program which squares with these principles.

HEALTH CARE IS A RIGHT

We believe that every American has a fundamental right to unimpeded, adequate health care. Over 2,000 years ago Aristotle expressed this great humanitarian ideal: "If we believe men have personal rights at all as human beings, they have an absolute right to such a measure of good health as society, and society alone, is able to give them."

Our affirmation is that health care as a right is a corrollary to the right of life itself. Senator Edward Kennedy echoed this belief in a statement made in April of this year to a meeting of the Health Security Action Conference which was attended by high officials of every major national labor union and by national leaders of many large social, religious, health, consumer, educational, and professional organizations, along with representatives of 30 States and District of Columbia health security action councils.

Speaking of the importance of good health to human rights, Kennedy said on April 14, 1975:

> As important as those bill of rights are about free assembly, and petition of our governments, and the right to free religion and a free press, if you are not going to be able to have a decent health care; if you are not going to be able to go down to worship or are too sick to be able to have a job, or are too sick to be able to participate in the vital opportunities of this country, as important and as magnificent as the bill of rights are, we are really failing our heritage.

Granted the presupposition that health care is a right of all citizens and not a privilege which is denied to many, our board of church and society believes that H.R. 21, entitled, the Health Security Act, best appreciates this fundamental right.

Following are nine United Methodist principles endorsed by our board. Each of these is pertinent to health care in West Virginia.

ACCESS TO HEALTH CARE

The first principle states that—

> All citizens should have equal access to the best available health care, including preventive services, regardless of wealth, social status, or any other condition.

H.R. 21 proposes a social health insurance plan, creating a national health trust fund from which nearly all personal health care services would be paid for the whole population. The bill provides for no deductibles, and there would be no coinsurance features or additional charges that would be made by providers directly to patients.

H.R. 21 would be a boon to health care in West Virginia in that it would provide equal health care of the best quality for the middle-, low-, and fixed-income people as well as for those in the high-income bracket.

One of our big problems in West Virginia is the lack of availability of services and facilities. Whereas other bills either have no provision for overcoming scarcities of health care personnel or facilities or else a weak provision for such, H.R. 21 would provide a health resources development fund which would improve access of our rural and low-income citizens to health care.

Regarding discriminatory practices in the provision of health care, H.R. 21 requires a nondiscrimination agreement by all participating providers of health care which goes beyond the reach of the American Hospital Association's proposal. H.R. 21 is clearly superior to other bills in providing equal access to all citizens to quality health care.

FREEDOM OF CHOICE

Principle 2 states:

> No arbitrary limits should be set about a person's right to choose among available doctors and facilities for medical care, nor should doctors be hindered from choosing the type of medical practice they wish to engage in, provided adequate medical standards of competence and responsibility are met in both cases.

Our board believes, in concurrence with the general conference board, that the lack of prepaid group practices or health maintenance organizations which provide comprehensive care to an enrolled population on a fixed annual basis is the greatest existing arbitrary limit to freedom of choice for patients and physicians.

H.R. 21 provides for the establishing of health maintenance organizations, and it specifically overrides various State laws which prohibit this option for the provision of health care.

H.R. 21 also requires continuing education for physicians as a condition of continued licensing, and it calls for national recognition of State licensing—when that licensing meets national standards—which will greatly allow increased freedom for physicians. This bill most responsibly guarantees freedom of choice to patients and physicians within the context of effective provision for control of the quality of health care services.

COMPREHENSIVENESS

The third principle reads: "Health care should be comprehensive, including physical, dental, mental and emotional fields of practice, and should focus on prevention as well as treatment and rehabilitation."

Of the bills proposed, H.R. 21 is clearly the most comprehensive, and it alone would provide for all basic personal health care, including catastrophic coverage to everyone without coinsurance or deductibles.

With regard to preventive services, bills which would call for coinsurance or deductibles would maintain many of the present barriers to preventive care. Many of the low-income families in West Virginia's cities and rural areas resist seeking medical attention until an illness which may have been prevented manifests itself. Their resistance to seek medical help is due to costs involved since they either do not have insurance or have a policy which does not include preventive or outpatient care as benefits.

Dr. John L. S. Holloman, president of Health and Hospitals Corp. of New York, made this statement in April:

> Those of us in local government whose responsibility it is to assure that citizens have access to adequate health care, and who provide the services or at least pay for them in part, have long since learned that preventive services directed toward community groups must be included in any national health insurance plan to insure that our goal is preservation of health rather than sickness care.

Our board, in agreement with Dr. Holloman, holds that an imposition of deductibles and coinsurance would only prevent preventive medical care. H.R. 21 would place no limits on preventive medical services. It calls for no deductibles, no coinsurance, no waiting periods. The bill also make no exclusions for preexisting conditions, a provision which adds to its comprehensiveness.

NATIONAL STANDARDS OF LICENSURE

The fourth principle: "National standards of health care service, including national standards of licensure, should be professionally established and kept under continual review and development."

H.R. 21 provides for a Health Security Board which would establish national standards for health care personnel, hospitals, nursing homes, clinics, dental offices, and health maintenance organizations.

The setting of national standards would serve to improve the quality of health care and encourage better use of health care personnel. These standards would also help to promote better planning of facilities. H.R. 21 includes a provision that State licensure meeting national standards would be nationally recognized.

LOCAL ADMINISTRATIVE RESPONSIBILITY

Principle 5 reads: "There should be national standards with policy-making and planning carried out at regional, State, area, and community levels."

H.R. 21 provides the broadest range of national standards for health care with regional, State, and local administration through regional offices of HEW and advisory councils at all levels.

CONSUMER REPRESENTATION

Principle 6: "Consumers should be represented on boards of professionals and public officials to design and administer every level of the national health care delivery system."

Other bills allow for no consumer representation or for consultation status. H.R. 21 is the only bill to call for a majority of consumer representatives on advisory councils at all levels of administration. H.R. 21 calls for public control of basic policies governing the program and full accountability for its finances and operation.

FUNDING FOR NEW SCHOOLS

Principle 7: "State and Federal Government should increase their financial support for new medical, psychological, dental and nursing schools, in order to enlarge the supply of health personnel, with special attention given to applications from women and all ethnic groups."

Though no bill has special attention given to anyone, H.R. 21's anti-discrimination clauses come close to this principle, which seeks to involve a broader range of persons in health fields. H.R. 21 also calls for Federal funding of new schools while other bills either do not call for funding or provide less adequate funding than that of H.R. 21.

PARAMEDICAL PERSONNEL

Principle 8: "Provision should be made for increased training and use of paramedical personnel under professional supervison and responsibility."

"Country Roads" may take one home in "Almost Heaven West Virginia," but the roads frequently lead to homes in communities in the hills which are quite distant from adequate health care facilities and personnel. The benefits of a paramedical program throughout our State should be obvious.

H.R. 21 would provide funds not only for the training of paramedics, but also for their use.

COSTS

Principle 9: "A universal program to provide all basic and necessary health care services should have costs shared by employers, individuals, and general revenue funds. Such a program should be publicly administered. The health care industry and health care professionals may be paid in a variety of ways, with special incentives to attract professionals to shortage areas."

H.R. 21 calls for costs to be shared by employees, employers, and general revenue taxes. The bill eliminates the need of paying private premiums in addition to payroll taxes. It eliminates variances in coverage or access to health care. It eliminates changes in coverage when one changes jobs or when one moves.

H.R. 21 alone offers what we believe to be an effective cost control method by providing prospective budgeting for the Nation's personal health care bill. Other bills will perpetuate waste by combining public and private insurance.

H.R. 21 would eliminate the need of maintaining sales forces, advertising promotions, eligibility checking, and paperwork involved in collections of copayments and deductibles from patients. Use of the social insurance method, like social security, would reduce costs by eliminating commissions and profit earning.

It is the feeling of our board of church and society in West Virginia that the best way to guarantee the right of health care is for our U.S. Congress to pass a national health insurance bill. It is our belief that this 94th Congress will be highly regarded if it assists our Nation to begin its third century by guaranteeing its citizens the inalienable right of "life, liberty, and the pursuit of happiness" with adequate quality health care.

For the sake of West Virginians and other Americans we urge you to pass H.R. 21 quickly. Thank you for this opportunity to address the matter of national health security.

[The appendix to the statement follows:]

APPENDIX

In the under-65 population in the United States:

22%, 42 million, had no hospital insurance

22.4%, 43.1 million, had no surgical insurance

22.8%, 43.3 million, had no in-hospital medical expense insurance

23.1%, 44 million, had no insurance to cover x-ray and laboratory exams when not in the hospital

64.8%, 123 million, had no insurance for visits to doctor's offices or doctor visits to homes

88.6%, 168 million, had no insurance against dental expense

35.4%, 767 million, had no insurance against the cost of prescribed drugs

38.5%, 73 million, had no insurance for private duty nursing

37.1%, 70 million, had no insurance for visiting nurse service

66.6%, 127 million, had no insurance for nursing home care

Source: Social Security Bulletin, February, 1975.

In West Virginia:

One-fourth of the people are poor.

A disproportionate number of people are elderly.

Half of our 55 counties have only 50% as many primary care physicians as are needed.

Because of unavailable medical services in many areas, we ranked at the bottom of a state-by-state listing.

We were 51st in Medicare payments since the inception of the program.

40 of our 55 counties are designated "health service scarcity areas" by a recent report of Community Health Service by criteria of CHS and National Health Service Corps.

A 1973 study showed that 8 counties had no hospitals or clinics registered with the Department of Health.

Each doctor in W.V. is responsible for 28% more people than the average U.S. doctor (including 242 residents & interns of WVU medical center and Charleston Area medical center.

25% of WV's doctors are over 60.

The nation's health bill in 1974 was $104 billion, a 10% increase over 1973. Our health bill has jumped over 100% in the eight years since 1967. The bill has jumped over 200% since 1964.

Despite the skills of personnel in the medical profession, our nation's collective health is not as good today as it was 20 years ago. The United States ranks 17th in infant mortality. We rank 22nd in life expectancy of males and 8th for females.

It is estimated that between 2 and 3 million unnecessary operations are performed each year. One of every four hospital beds is filled by someone who does not need to be there on any given day.

Only about one-fourth of all personal health care bills are paid by health insurance. The other three-fourths is paid from consumers' pockets, savings, families, and government. Medicare is paying less than half of the bills of our elderly citizens

Mr. ROSTENKOWSKI. Thank you.

Dr. Sade?

STATEMENT OF ROBERT M. SADE, M.D., CHARLESTON, S.C.

Dr. SADE. I am Robert Sade, a practicing surgeon and an academician at the University of South Carolina. I am speaking for myself alone as a sovereign citizen of the United States.

None of the bills now before Congress pertaining to national health insurance or to any aspect of our health care system should be passed. Because of limitations of time I will leave the pratcical arguments to others and simply note the fact that there are no crises in health care. There is no crisis of quality, there is no crisis of cost, and there is no crisis of distribution of health care personnel.

There are problems, of course, but they are perfectly soluble without the intrusion of coercive Federal legislation that can only exacerbate the problems of a health care system that, as a whole, is the most successful in the world. There is, in fact, good evidence now to suggest that if a national health bill is passed, the cost of health care will go up rather than down, and the quality of health care will go down rather than up.

Instead of presenting statistical arguments, I will devote my brief time to persuading you that all legislation pertaining to health care is not only futile and counterproductive, but is also immoral. Such laws are immoral because they are all based on the premise that health care is a right and must, therefore, be guaranteed to all citizens by the State.

Health care is not a right. Rights are not bestowed by the State. They are not created by the wants or needs of any group of people. They are determined by the nature of man as a living creature: he has the right to his own life. In order to live his life, each man has at his disposal a unique and efficient mechanism, his mind. To exercise his right to life, he must be allowed to use his mind freely, and to act on his own judgment.

These basic rights can be abrogated by government through improper exercise of its monopoly on the use of force, when it uses the force of law to prevent its citizens from acting on their own judgments.

Patients and physicians don't have fewer rights than any other citizens. The new rights defined by health legislation are destroying true human rights. The right of a patient to have his throat looked at when he has a cold is, through legislation, destroying his fundamental right to privacy in his relationship with his physician, his right to contract voluntarily with a health practitioner for services of their choice, and his right to decide how to allocate his own resources between health care and other goods and services.

The right to get something for nothing in the form of cheap health care is destroying the fundamental right of health practitioners to act on the basis of their own judgments rather than using a bureaucratic cookbook to diagnose and treat illness, their right to contract voluntarily with their patients for specific services, and their right to earn a living by uncoerced interaction with their patients.

Any doctor who is forced by law to join a group or hospital he does not choose, or is prevented by law from prescribing a drug he thinks is best for his patient, or is compelled by law to make any decision he would not otherwise have made, is being forced to act against his own judgment, which means forced to act against his own life. He is also being forced to violate his most basic professional commitment, that of using his own best judgment at all times for the greatest benefit of his patient.

Health care is not a right, nor is it a privilege. It is a service offered by physicians and other health workers to those who wish to obtain it. Acceptance of the notion that health care is a right undercuts and will eventually destroy the concept of individual rights upon which a free society is based. The substitution of legislated rights for true individual rights is taking place at an accelerating rate. This debasement of rights provides the vehicle that will eventually lead us into a totally planned society.

There is a health care crisis today. It is the threat of State control of the health care industry. The Government is not responsible for all of our problems, but the poor planning, mismanagement and dislocations of incentives that are inherent in any bureaucratic intervention have exacerbated rather than improved the problems to which they are addressed. They will continue to do so, as they have in every country where the State controls health care.

Physicians recognize that their first and highest professional obligation is to the welfare of their patients. In order to fulfill that obligation they have to be left free to exercise their own best judgment in their patient's interest.

Patients will discover that they themselves are the real victims of the concept that health care is a right, because their privacy is being invaded by Federal computers, their health is being tampered with and their doctors are being forced to divert their loyalty, formerly belonging only to patients, to the paying Uncle who is calling the tune.

I ask you, as people of integrity and intelligence, to recognize the futility of legislative intervention into our health care system and the immorality of vitiating the fundamental rights of patients and health practitioners by those interventions. All the health care bills now before you are futile and do, in one way or another, undermine fundamental rights.

Any of these bills that become law will not only endanger the high quality of health care now available, but will further erode the fabric of our free society.

Thank you.

[The appended material follows:]

NATIONAL HEALTH INSURANCE RX FOR DISASTER

(By Robert M. Sade, M.D.)*

Control of health care services by government is not new. The modern history of social health legislation began in 1883, when Otto von Bismarck pushed through the German legislature his Sickness Insurance Law. The passage of that law was necessary, Bismarck thought, as a pre-emptive move against the growing political power of the new German socialist movement, and was designed to molllify the working people with a paternalistic medical program. Soon after that, many other European countries developed social medical programs; for example, England passed a series of laws building on the Poor Laws of the 19th century, starting with the National Health Insurance Act of 1912 and culminating in the National Health Service of 1948. By the mid 1950's almost all European countries had health care systems controlled by the State.

The purely political goal of medical legislation in most countries has usually been attained: consolidation of political power by giving "free" goods or services to the electorate. But that political goal has rarely been explicit. The ostensible reason for the government taking control has been improvement of the people's health by improvement of the "quality" of health care, and by making care available to more people, said improvements to be measured in terms of standard health indices. Historically, none of these nonpolitical goals has been consistently achieved by any nation merely by legislatively controlling its health care industry.

Government involvement in medical care in the United States began more recently. Except for some sharply limited areas of public health and medical care for military personnel, there was essentially no governmental involvement in health care in America until 1965, when the Medicare and Medicaid programs were passed. Because of the huge cost overruns of those programs, remedial legislation has been required; the most noxious of the cost control measures is the 1972 Bennett Amendment to the Social Security Act, which establishes Professional Standards Review Organizations (PSRO's). Several bills to establish a national health insurance program are now before Congress.

The range of legislation being considered for control of the health care industry is quite broad. Each law is designed as a partial or complete solution to one or more of three perceived problems: *excessive cost*, *low quality*, and *unavailability of medical care*. Personal aggrandizement of certain politicians is unquestionably one of the main, though subliminal, motivations behind the current legislation. If we are to believe taht this is not the only motivation, then the politicians must be able to show that the crises they cite are real. This they have failed to do.

HEALTH CARE COSTS

Has the rise in cost of medical care been out of proportion to that of the general economy? It has not, as the following facts will demonstrate: between 1960 and 1970, the cost of health care increased about 50 percent. Those politicians whose virtues omit objectivity and honesty point to a rise in the cost of living index (representing mostly commodities) during that same time period, of only 20 percent, and call it proof of the skyrocketing costs of health care. What they don't say is that the cost of services, the category to which health care belongs, also rose 50 percent during the same period of time. And what of the unconsionable "killing" that doctors are making with excessive fees? Between 1955 and

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*Robert M. Sade is a physician on the staff of the Children's Hospital Medical Center in Boston. His article "Medical Care as a Right: A Refutation" (which appeared in REASON's Special Issue on "Libertarian Politics and Issues" in September 1972) caused considerable controversy within the medical profession when it was first published in the New England Journal of Medicine in 1972.

1970, the income of physicians rose one-half a percent less than overall wages during the same period of time. A large part of the increase in cost of health care has been due to mismanaged government intervention into both the general economy and the medical marketplace.

QUESTIONS OF QUALITY

Is the quality of health care in America low? Over and over again, we hear the charge that there is too much unnecessary surgery done. How do the politicians know that? One of their sources of information is a published statement by the former General Director of the Massachusetts General Hospital, John Knowles, that "incredible amounts" of unnecessary surgery was being done. When Dr. Knowles was invited by the Massachusetts Medical Society to produce any evidence to support this charge he was unwilling or unable to do so. For making this irresponsible statement, he became the first physician in 50 years to be officially censured by the Massachusetts Medical Society. It is upon evidence such as his that charges of low quality of health care are made.

Another avenue of support for the low quality charge is the citation of infant mortality statistics. That argument is still offered almost daily despite the fact that it was debunked years ago. Infant mortality means different things in different countries statistical methods vary from country to country, and even within countries, such as ours. There are no standard criteria for determining infant mortality; even if there were standard criteria, countries with people of small average statute would have infants of small size, therefore, an artifically lower infant mortality; reporting of birth is the responsibility of parents in some countries, and reporting of deaths is not rigidly enforced in others; the extent to which legalized abortion in some countries lowers infant mortality is unknown; there are racial differences not related to socioeconomic level in the rate of infant deaths. If the United States is to be compared to another nation, it should be to one of about equal population, spread out over an entire continent, and of multi-ethnic origin. Such a country is the Soviet Union. In the United States, with its emphasis on free enterprise in medical care, with a "chaotic nonsystem," the infant mortality rate in 1970 was 19.7 per 1000 births. In Russia, in the same year, with its 60-year tradition of state-controlled medicine, with a heavy emphasis on public health and preventive medicine, the infant mortality rate was 28.0, 40 percent higher than ours.

Other evidence often cited as indicating low quality is that people on the whole are terribly dissatisfied with their health care. This is the least defensible of the attacks on American medicine. Several studies done over the past few years have had consistent findings a large number of people (around 75 percent) believe that there is a crisis in medical care at this time, yet in the same studies, only 10 to 15 percent were unhapply with the overall quality of their own health care. This discrepancy can be accounted for only by a great deal of misrepresentation by loud public voices shouting "crisis" over and over. Annual surveys over the past few years show the medical profession to be the most trusted identifiable group in the country. Congress and the executive branch are consistently low on the same lists.

UNAVAILABILITY OF CARE

The third problem that has invited legislative intervention has been the alleged unavailability of medical care due to costs that could not be afforded by the poor. an overall shortage of physicians, and maldistribution of those physicians that there are. Even before there was a significant degree of intrusion by the government into health care delivery, the poor were not inadequately cared for. For example, one measure of the extent of medical care is the number of hospital admissions per thousand people in a given population. During the years 1963–1974, families with income under $2000 a year had 124 hospital admissions per thousand people. Families with a near poverty income, $2000–$4000 a year, had 142 admission per thousand. These figures contrast with hospital admissions in families with incomes of over $10,000, who had 120 admissions per thousand. Of course, it could be argued that the quality of care offered during these admissions was suboptimal. Not only is it difficult to find evidence of low quality, it seems quite likely that the opposite is true; large numbers of poor people live near major teaching institutions where the quality of medical care may be at its highest. It is likely that a disproportionate number of admissions for the poor were to such institutions. Those who argue that poor people need significantly more hospitalization than others have yet to produce evidence that this is true.

Another myth tells the tale that poor people cannot get to see a physician when they need one. In 1970 the Department of HEW surveyed the medical care obtained by persons in the age group from 18 to 64. During that year, 68 percent of the low income groups saw a physician; in the middle income groups, 69 percent saw a physician; and in the high income groups, the proportion was 70 percent. There was no significant difference between those groups. Poor people in central cities, contrary to popular belief, were better off than others: 71 percent of that group saw a physician during 1970. But those figures do not tell the whole story since some of the people who were seen by a physician were seen more than once. The mean number of visits to a physician during the year 1970 was five in the low income group, four in the middle income group, and 3.7 in the high income group. It is clear from these figures that poor people can and do obtain medical care.

Is there a shortage of physicians? Since 1966 the shortage has been estimated at 50,000. It is still estimated at 50,000. Yet, over the past eight years there has been a net increase of more than 62,000 physicians. The number of physicians is now growing three times as fast as the general population. I submit that we are headed toward a doctor excess which may have catastrophic effects upon physicians as a group, as did the mass of overproduction of engineers following the Sputnik crisis of the late 1950's. As you will recall, our overreaction to that "crisis" resulted in massive layoffs of Ph.D. engineers, many of whom had to work as gas station attendants and taxicab drivers until they could be re-educated into other positions. Ironically, a few universities developed crash programs for putting some of those engineers through shortened educational programs to turn them into physicians.

What of maldistribution? The most that can be said is that there is *uneven* distribution. Washington, D.C., for example, has 410 physicians per 100,000 population in 1971, Florida had 168, while North Dakota had 96. But what does number of physicians per unit population mean? Does it mean lower quality of health care? If infant mortality is any measure of health care, it is easily shown that there is no positive correlation between those statistics and physician/patient ratio. For example, in 1971 Washington's high physician/population ratio accompanied an infant mortality rate of 28.5 per 1000 births, Florida's intermediate ratio was associated with a mortality rate of 20.7, while North Dakota's low physician/population ratio accompanied an infant mortality rate of 15.3.

It is doubtful that many social planners believe that decreasing the number of doctors will improve infant mortality statistics, yet vital statistics can be manipulated to give this impression. In fact, the number of physicians in a given area has far less to do with health than with such factors as housing, sanitation, and diet.

As a further example, during World War II there was a sudden efflux of thousands of physicians from communities all over the country. Many places suddenly found themselves with a quarter to a half of their previous number of physicians and some communities were without any. Yet, looking at any given statistical measure of health, no significant differences can be demonstrated between the periods before, during and after the war.

We should also remember that in the latter half of the 20th century, uneven distribution has been smoothed out considerably by the availability of a variety of forms of transportation over small or large distances. Only two percent of the population of the United States is more than 25 miles from a hospital and only one-tenth of one percent is more than 50 miles from a hospital.

POSSIBLE LEGISLATIVE SOLUTIONS

The "health care crisis" is largely a construction of demagoguery. Yet laws have been passed and new laws are being considered to combat the imagined crisis. A description of the ways in which the specific problems are being attacked follows.

Control of costs.—The most direct method of cost control is price fixing, which was in effect between August 15, 1971, and April 30, 1974. The general failure of wage and price controls to prevent inflation is well known. Indirect cost controls included in legislation currently being considered or already passed are (1) mechanisms to reduce artificially the number of hospital admissions and length of hospital stay, to the detriment of patients, (2) restricted lists of drugs permissible for physicians to prescribe, (3) dictation of the type of health care facility in which patients will be treated, (4) subsidies to ambulatory health care centers, and (5) the creation of government controlled comprehensive health planning agencies. These measures clearly intrude into the doctor-patient relationship, negate the physician's professional judgment, and erode the patient's individual rights.

Quality control.—The major mechanism to control quality is the establishment of a set of standards to which physicians must gear their medical practices, and peer review systems in which some doctors both prospectively and retrospectively police the judgment and decisions of other doctors. We do not have to wait until 1984 this Orwellian law has already been passed and is in the implementation phase, as will be discussed shortly.

Increase of availability.—Measures to improve the availability of health care include establishment of government agencies and programs to pay for the care of particularly needy groups, such as the poor and the elderly. Medicare and Medicaid take this approach and have now been in operation for seven years. Another measure being considered is to make private insurance available to everyone by direct subsidy through certificates or tax credits. The number of physicians is being artifically increased at a rapid rate, as pointed out before, by subsidies to both medical schools and medical students. Physicians have been brought to rural areas by programs allowing young doctors to spend two years in such areas rather than serving in the military. This approach is likely to work less well as military medical practice is made more attractive and the need for a doctor draft diminishes.

LAWS ALREADY PASSED

Let us now look at specific applications of these approaches. Medicare and Medicaid were passed in 1965 as Title XVIII and XIX of the Social Security Act. They were addressed to the problem of availability, and were designed to pay the health care bills of indigents and the elderly. Like most social legislation, these bills, especially Title XIX, have produced more problems than they have solved. The greatest problem was their inflationary effect on the health care industry; this is inevitable when a greatly increased demand is placed on the market with a relatively inflexible supply. One outstanding characteristic of these programs was their huge cost overruns: by 1970, Medicare had cost twice as much as the original projections, and Medicaid had nearly bankrupted several states, including California and New York.

Many cutbacks and alterations have been engendered by the massive expense of these programs, but the worst by far was the passage in October 1972, of Public Law 92–603, the Bennett Amendment establishing Professional Standards Review Organizations (PSRO). PSRO's exist mainly to determine whether specific health care services are medically necessary, and whether hospital services could be provided as well on an outpatient basis or in a less expensive facility. Each PSRO is authorized to overrule in advance a physician's judgment of whether hospitalization or treatment is necessary. Even if a service is deemed necessary, the PSRO is authorized to determine who should provide the service (which type of practitioner, hospital, etc.).

The PSRO is authorized to examine the records of any practitioner or provider of services; this will utterly, yet legally, destroy the confidentiality of all transactions between patient and doctor and make available to the federal bureaucracy the confidential medical and psychiatric histories of everyone subject to PSRO's—and this will soon include everyone in the country. Hospitals, private doctors' offices and other facilities are also subject to arbitrary inspection by employees of PSRO. Physicians and other providers are required to provide services limited to those that meet minimal standards of necessity and quality as determined by the PSRO, and all standards are subject to the authority of the Secretary of HEW. Those standards might be, in many cases probably will be, in disagreement with a physician's own training and experience; nevertheless, the Secretary of HEW can punish him for transgressing those standards by such devices as publication of the names of practitioners who fail to conform to the standards and fines of up to $5,000. All this—bureaucratization and subjugation of physicians, destruction of the doctor-patient relationships, and gross invasion of the patient's privacy—is being done in the name of better medical care.

BILLS BEING CONSIDERED

Discussion of the full range of legislative approaches to deal with the health care crisis must begin with the labor-backed Health Security Act (HR 22, S 3) the most comprehensive proposal under consideration. Its chance for passage diminished dramatically when Senator Kennedy withdrew his support in April 1974, in favor of a compromise bill which will be described shortly.

Benefits under the Health Security Act would cover all citizens of the United States. The problem of cost control would be approached by several routes: direct, arbitrary control of fees and per capita payments by an all powerful Health Security Board; the requirement of Board approval of hospital operating costs; *limitation of medication expenses* by establishment of a *list of drugs* that can be prescribed by physicians and *of the diseases and conditions* for which they may be used; listing of the prices that a drugstore can charge for dispensing a drug; and a *fixed budgeted amount of money* available for all health care, to be distributed by the Board on a regional basis and into types of care delivery that the Board believes to be most cost effective.

In an attempt to assure high quality of care, the bill would establish a variety of mechanisms of *peer review*, establish national standards for licensing, overriding the current state licensing system, and establish requirements for continuing education of health practitioners. *Any practitioner who fails to adhere to the edicts of the Board* could have his participation under the Health Security Act suspended or completely terminated by the Board. Since the system will be universal and compulsory, this provision means that the Board will have financial life and death control over all health practitioners in the United States.

The Health Security Act also addresses the problem of unavailability of health personnel and facilities. It would establish several mechanisms for centralized planning of the supply and distribution of personnel and facilities and the organization of health services. It would provide special technical assistance and financial subsidies to health maintenance organizations, foundations, and other types of prepaid comprehensive health plans; it would *subsidize* and control the recruitment, education, and training of health personnel in the medical specialties in which the Board thinks there is a shortage, as well as providing for the training of new types of health personnel, as the Board desires.

President Nixon proposed his Comprehensive Health Insurance Plan (CHIP) (HR 12684, S 2970) in February 1974. It would be financed by a compulsory tax on employers, who will pay 75 percent of the premium for all their employees. The insurers would be private insurance companies but the content of insurance plans (which services can be rendered under what conditions) would be determined by the State. Control of costs and assurance of quality would be done largely by expansion of the PSRO program to cover outpatient as well as inpatient services. Reimbursement of physicians would be on the basis of state established fee schedules. There is a special provision for a subsidized catastrophic illness plan under which no family's liability for medical expenses in one year could exceed $1,500. Medicare would continue almost as it is now, but Medicaid would be replaced by a separate government health insurance plan administered by the states for poor, medically indigent, and high-risk people; the Federal Government would pay about 75 percent of the cost. Other health care cost controls would include establishment of state planning agencies to approve capital investments, payment for drugs on a lowest price basis, and predetermined reimbursement systems for hospitals.

CHIP does very little to correct alleged physician shortages and maldistribution, but Nixon has presented to Congress several suggestions in certain health service categories in which he believes there are currently shortages. His Health Maintenance Organization (HMO) bill has already been passed; it subsidizes the development of HMO's with $375 million of general funds.

The Comprehensive National Health Insurance Act (HR 13870, S 3286) is a compromise bill proposed by Senator Kennedy and Congressman Mills in April 1974, and is designed for early passage. It is similar to President Nixon's. Its cost will be about the same, about 40 billion dollars; insurance premium costs will be about the same, as will the co-insurance and deductible aspects. The plan will be carried out mainly through private insurance companies as intermediaries, with employers paying about three-fourths of the cost, and employees, about one-fourth. Medicare will be maintained with slightly expanded benefits for those over age sixty-five.

The differences between this bill and Nixon's are mainly those of details. Low income employees will pay less than those with high incomes; the collection of premiums will be through the Social Security System instead of private insurance companies; administration of the health plan will not reside in HEW, but in a Social Security office divorced from HEW; the catastrophic illness liability is reduced to $1,000.

Unlike the Nixon plan, this one will be compulsory for all citizens of the United States, but physicians will be free to participate in the program or not. However, the patient must pay a nonparticipating physician out of pocket, so anyone desiring a private doctor will have to pay twice: once for his government insurance, and again to the doctor. Senator Kennedy, at his news conference in April, assured us that all of the basic ideas and goals of his 1973 Health Security Act are incorporated in this one.

Another main contender among the pending national health insurance bills is the AMA's Medicredit (HR 2222, S 5444). It is aimed at making health care available to all citizens by providing them with private health insurance coverage through a system of certificates and tax credits that are assigned according to ability to pay. It also provides catastrophic illness coverage, regardless of previous medical history. This bill is directed entirely at availability of professional care, maintaining virtually intact the current system of medical care. There are no cost or quality control provisions in the AMA bill.

Many other bills provide their own variations of the themes presented by the major contenders. The American Hospital Association bill (HR 1) provides for administration of a national program locally by Health Care Corporations. The proposal of the health insurance industry (HR 5200, S 1100), provides tax incentives for private insurance as well as catastrophic illness coverage. The Long-Ribicoff bill (S 2513) constructs a new comprehensive national Medicaid plan, along with catastrophic insurance.

A RIGHT TO HEALTH CARE?

All of these bills have several practical shortcomings, some of which have been described. But they share a major flaw: they are all based on the premise that health care is a right, and must therefore be guaranteed to all citizens by the State. But rights are not bestowed by the State, nor are they created by the wants or needs of any group of people. The facts of Man's nature as a rational being determine his rights. It is the function of government to protect the primary right of people to pursue their own happiness and their own professional or economic goals. If government intervenes, with its monopoly on the use of force, on the side of the economically weak, the end result will be a totalitarian state of socialism or communism. If it intervenes with force on behalf of the economically strong, the result will be a totalitarian state of fascism. A frighteningly close view of the latter has been provided by Watergate and associated stories.

Health care is not a right, nor is it a privilege; it is a *service* offered by physicians and other health workers to those who wish to obtain it. Acceptance of the notion that health care is a right undercuts and will eventually destroy the concept of individual rights upon which a free society is based. The substitution of pseudorights for true individual rights is taking place at an accelerating rate in this country; this debasement of rights provides the vehicle that will eventually carry us into the brave new world of a totally planned society.

There *is* a health care crisis today. It is the threat of State control of the health care industry. The government is not responsible for all of our problems, but the poor planning, mismanagement, and dislocations of incentive that are inherent in any coercive bureaucratic intervention have exacerbated rather than improved the problems to which they were addressed.

What is the solution to this crisis, how should the threat of coercive control of health care delivery be answered? The use of physical force, or the threat of it, must be declared totally invalid as a means of achieving any goals, individual or social. Government by its very nature is coercive, and its power lies entirely in its monopoly on the legitimate use of physical violence. Government intervention and control must therefore, be kept entirely outside not only the relationship between doctors and patients, between patients and their insurance companies, between nurses and their hospitals, but outside all areas of economic life.

Physicians recognize that their first and highest professional obligation is to the welfare of their patients. In order to fulfill that obligation, they must be left free to exercise their own best judgment in their patients' interest.

Patients will discover that they themselves are the real victims of the concept that health care is a right; they will suffer the most from the construction of PSRO's and the nationalization of medicine. It is their privacy that is being invaded by Federal computers, their health that is being tampered with, and their doctors who are being forced to divert their loyalty, formerly belonging only to patients, to the paying Uncle who is calling the tune.

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SPECIAL ARTICLE

MEDICAL CARE AS A RIGHT: A REFUTATION

(By Robert M. Sade, M.D.)

Abstract.—From man's primary right—the right to his own life—derive all others, including the rights to select and pursue his own values, and to dispose of these values, once gained, without coercion. The choice of the conditions under which a physician's services are rendered belongs to the physician as a consequence of his right to support his own life.

If medical care, which includes physician's services, is considered the right of the patient, that right should properly be protected by government law. Since the ultimate authority of all law is force of arms, the physician's professional judgment—that is, his mind—is controlled through threat of violence by the state. Force is the antithesis of mind, and man cannot survive qua man without the free use of his mind. Thus, since the concept of medical care as the right of the patient entails the use or threat of violence against physicians, that concept is anti-mind—therefore, anti-life, and, therefore, immoral.

The current debate on health care in the United States is of the first order of importance to the health professions, and of no less importance to the political future of the nation, for precedents are now being set that will be applied to the rest of American society in the future. In the enormous volume of verbiage that has poured forth, certain fundamental issues have been so often misrepresented that they have now become commonly accepted fallacies. This paper will be concerned with the most important of these misconceptions, that health care is a right, as well as a brief consideration of some of its corollary fallacies.

RIGHTS—MORALITY AND POLITICS

The concept of rights has its roots in the moral nature of man and its practical expression in the political system that he creates. Both morality and politics must be discussed before the relation between political rights and health care can be appreciated.

A "right" defines a freedom of action. For instance, a right to a material object is the uncoerced choice of the use to which that object will be put; a right to a specific action, such as free speech, is the freedom to engage in that activity without forceful repression. The moral foundation of the rights of man begins with the fact that he is a living creature: he has the right to his own life. All other rights are corollaries of this primary one; without the right to life, there can be no others, and the concept of rights itself becomes meaningless.

The freedom to live, however, does not automatically ensure life. For man, a specific course of action is required to sustain his life, a course of action that must be guided by reason and reality and has as its goal the creation or acquisition of material values, such as food and clothing, and intellectual values, such as self-esteem and integrity. His moral system is the means by which he is able to select the values that will support his life and achieve his happiness.

Man must maintain a rather delicate homeostasis in a highly demanding and threatening environment, but has at his disposal a unique and efficient mechanism for dealing with it: his mind. His mind is able to perceive, to identify percepts, to integrate them into concepts, and to use those concepts in choosing actions suitable to the maintenance of his life. The rational function of mind is volitional, however; a man must *choose* to think, to be aware, to evaluate, to make conscious decisions. The extent to which he is able to achieve his goals will be directly proportional to his commitment to reason in seeking them.

The right to life implies three corollaries: the right to select the values that one deems necessary to sustain one's own life; the right to exercise one's own judgment of the best course of action to achieve the chosen values; and the right to dispose of those values, once gained, in any way one chooses, without coercion by other men. The denial of any one of these corollaries severely compromises or destroys the right to life itself. A man who is not allowed to choose his own goals, is prevented from setting his own course in achieving those goals and is not free to dispose of the values he has earned is no less than a slave to those who usurp those rights. The right to private property, therefore, is essential and indispensable to maintaining free men in a free society.

Thus, it is the nature of man as a living, thinking being that determines his rights—his "natural rights." The concept of natural rights was slow in dawning on human civilization. The first political expression of that concept had its beginnings in 17th and 18th century England through such exponents as John Locke and Edmund Burke, but came to its brilliant debut as a form of government after the American Revolution. Under the leadership of such men as Thomas Paine and Thomas Jefferson, the concept of man as a being sovereign unto himself, rather than a subdivision of the sovereignty of a king, emperor or state, was incorporated into the formal structure of government for the first time. Protection of the lives and property of individual citizens was the salient characteristic of the Constitution of 1787. Ayn Rand has pointed out that the principle of protection of the individual against the coercive force of government made the United States the first moral society in history.[1]

In a free society, man exercises his rights to sustain his own life by producing economic values in the form of goods and services that he is, or should be, free to exchange with other men who are similarly free to trade with him or not. The economic values produced, however, are not given as gifts by nature, but exist only by virtue of the thought and effort of individual men. Goods and services are thus owned as a consequence of the right to sustain life by one's own physical and mental effort.

If the claim of natural rights is interrupted, and the right of a loaf of bread, for example, is proclaimed as primary (avoiding the necessity of earning it), every man owns a loaf of bread, regardless of who produced it. Since ownership is the power of disposal,[2] every man may take his loaf from the baker and dispose of it as he wishes with or without the baker's permission. Another element has thus been introduced into the relation between men: the use of force. It is crucial to observe who has initiated the use of force; it is the man who demands unearned bread as a right, not the man who produced it. At the level of an unstructured society it is clear who is moral and who immoral. The man who acted rationally by producing food to support his own life is moral. The man who expropriated the bread by force is immoral.

To protect this basic right to provide for the support of one's own life, men band together for their mutual protection and form governments. This is the only proper function of government: to provide for the defense of individuals against those who would take their lives or property by force. The state is the repository for retaliatory force in a just society wherein the only actions prohibited to individuals are those of physical harm or the threat of physical harm to other men. The closest that man has ever come to achieving this ideal of government was in this country after its War of Independence.

When a government ignores the progression of natural rights arising from the right to life, and agrees with a man, a group of men, or even a majority of its citizens, that every man has a right to a loaf of bread, it must protect that right by the passage of laws ensuring that everyone gets his loaf—in the process depriving the baker of the freedom to dispose of his own product. If the baker disobeys the law, asserting the priority of his right to support himself by his own rational disposition of the fruits of his mental and physical labor, he will be taken to court by force or threat of force where he will have more property forcibly taken from him (by fine) or have his liberty taken away (by incarceration). Now the initiator of violence is the government itself. The degree to which a government exercises its monopoly on the retaliatory use of force by asserting a claim to the lives and property of its citizens is the degree to which it has eroded its own legitimacy. It is a frequently overlooked fact that behind every law is a policeman's gun or a soldier's bayonet. When that gun and bayonet are used to initiate violence, to take property or to restrict liberty by force, there are no longer any rights, for the lives of the citizens belong to the state. In a just society with a moral government, it is clear that the only "right" to the bread belongs to the baker, and that a claim by any other man to that right is unjustified and can be enforced only by violence or the threat of violence.

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[1] Rand A: Man's rights, Capitalism: The unknown ideal. New York, New American Library, Inc., 1967, pp. 320–329.

[2] Von Mises L: Socialism: An economic and sociological analysis. New Haven, Yale University Press, 1951, pp. 37–55.

RIGHTS—POLITICS AND MEDICINE

The concept of medical care as the patient's right is immoral because it denies the most fundamental of all rights, that of a man to his own life and the freedom of action to support it. Medical care is neither a right nor a privilege; it is a service that is provided by doctors and others to people who wish to purchase it. It is the provision of this service that a doctor depends upon for his livelihood, and is his means of supporting his own life. If the right to health care belongs to the patient, he starts out owning the services of a doctor without the necessity of either earning them or receiving them as a gift from the only man who has the right to give them: the doctor himself. In the narrative above substitute "doctor" for "baker" and "medical service" for "bread." American medicine is now at the point in the story where the state has proclaimed the nonexistent "right" to medical care as a fact of public policy, and has begun to pass the laws to enforce it. The doctor finds himself less and less his own master and more and more controlled by forces outside of his own judgment.

For instance, under the proposed Kennedy-Griffiths bill,[3] there will be a "Health Security Board," which will be responsible for administering the new controls to be imposed on doctors, hospitals and other "providers" of health care (Sec. 121). Specialized services, such as major surgery, will be done by "qualified specialists" [Sec. 22(b)(2)], such qualifications being determined by the Board (Sec. 42). Furthermore, the patient can no longer exercise his own initiative in finding a specialist to do his operation, since he must be referred to the specialist by a nonspecialist—i.e., a general practitioner or family doctor [Sec. 22(b)]. Licensure by his own state will not be enough to be a qualified practitioner; physicians will also be subject to a second set of standards, those established by the Board [Sec. 42(a)]. Doctors will no longer be considered competent to determine their own needs for continuing education, but must meet requirements established by the Board [Sec. 42(c)]. The professional staff of a hospital will no longer be able to determine which of its members are qualified to perform which kinds of major surgery; specialty-board certification or eligibility will be required, with certain exceptions that include meeting standards established by the Board [Sec. 42(d)].

Control of doctors through control of the hospitals in which they practice will also be exercised by the Board by way of a list of requirements, the last of which is a "sleeper" that will by its vagueness allow the Board almost any regulation of the hospital: the hospital must meet "such other requirements as the Board finds necessary in the interest of quality of care and the safety of patients in the institution" [Sec. 43(i)]. Hospitals will also not be allowed to undertake construction without higher approval by a state agency or by the Board (Sec. 52).

In the name of better organization and co-ordination of services, hospitals, nursing homes and other providers will be further controlled through the Board's power to issue directives forcing the providers to furnish services selected by the Board [Sec. 131(a)(1), (2)] at a place selected by the Board [Sec. 131(a)(3)]. The Board can also direct these providers to form associations with one another of various sorts, including "making available to one provider the professional and technical skills of another" [Sec. 131(a)(B)], and such other linkages as the Board thinks best [Sec. 131(a)(4)(C)].

These are only a few of the bill's controls of the health-care industry. It is difficult to believe that such patent subjugation of an entire profession could ever be considered a fit topic for discussion in any but the darkest corner of a country founded on the principles of life and liberty. Yet the Kennedy-Griffiths bill is being seriously debated today in the Congress of the United States.

The irony of this bill is that, on the basis of the philosophic premises of its authors, it does provide a rationally organized system for attempting to fulfill its goals, such as "making health services available to all residents of the United States." If the government is to spend tens of billions of dollars on health services, it must assure in some way that the money is not being wasted. Every bill currently before the national legislature does, should, and must provide some such controls. The Kennedy-Griffiths bill is the closest we have yet come to the logical conclusion and inevitable consequence of two fundamental fallacies: that health care is a right, and that doctors and other health workers will function as efficiently serving as chattels of the state as they will living as sovereign human beings. It is not, and they will not.

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[3] Kennedy EM: Introduction of the Health Security Act. Congressional Record 116–S 14338–S 14361, 1970.

Any act of force is anti-mind. It is a confession of the failure of persuasion, the failure of reason. When politicians say that the health system must be forced into a mold of their own design, they are admitting their inability to persuade doctors and patients to use the plan voluntarily; they are proclaiming the supremacy of the state's logic over the judgments of the individual minds of all concerned with health care. Statists throughout history have never learned that compulsion and reason are contradictory, that a forced mind cannot think effectively and, by extension, that a regimental profession will eventually choke and stagnate from its own lack of freedom. A persuasive example of this is the moribund condition of medicine as a profession in Sweden, a country that has enjoyed socialized medicine since 1955. Werkö, a Swedish physician, has stated: "The details and the complicated working schedule have not yet been determined in all hospitals and districts, but the general feeling of belonging to a free profession, free to decide—at least in principle—how to organize its work has been lost. Many hospital-based physicians regard their work now with an apathy previously unknown."[4] One wonders how American legislators will like having their myocardial infarctions treated by apathetic internists, their mitral valves replaced by apathetic surgeons, their wives' tumors removed by apathetic gynecologists. They will find it very difficult to legislate self-esteem, integrity and competence into the doctors whose minds and judgments they have throttled.

If anyone doubts that health legislation involves the use of force, a dramatic demonstration of the practical political meaning of the "right to health care" was acted out in Quebec in the closing months of 1970.[5] In that unprecedented threat of violence by a modern Western government against a group of its citizens, the doctors of Quebec were literally imprisoned in the province by Bill 41, possibly the most repressive piece of legislation ever enacted against the medical profession, and far more worthy of the Soviet Union or Red China than a western democracy. Doctors objecting to a new Medicare law were forced to continue working under penalty of jail sentence and fines of up to $500 a day away from their practices. Those who spoke out publicly against the bill were subject to jail sentences of up to a year and fines of up to $50,000 a day. The facts that the doctors did return to work and that no one was therefore jailed or fined do not mitigate the nature or implications of the passage of Bill 41. Although the dispute between the Quebec physicians and their government was not one of principle but of the details of compensation, the reaction of the state to resistance against coercive professional regulation was a classic example of the naked force that lies behind every act of social legislation.

Any doctor who is forced by law to join a group or a hospital he does not choose, or is prevented by law from prescribing a drug he thinks is best for his patient, or is compelled by law to make any decision he would not otherwise have made, is being forced to act against his own mind, which means forced to act against his own life. He is also being forced to violate his most fundamental professional commitment, that of using his own best judgment at all times for the greatest benefit of his patient. It is remarkable that this principle has never been identified by a public voice in the medical profession, and that the vast majority of doctors in this country are being led down the path to civil servitude, never knowing that their feelings of uneasy foreboding have a profoundly moral origin, and never recognizing that the main issues at stake are not those being formulated in Washington, but are their own honor, integrity and freedom, and their own survival as sovereign human beings.

SOME COROLLARIES

The basic fallacy that health care is a right has led to several corollary fallacies, among them the following:

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[4] Werkö L: Swedish medical care in transition. N Engl J Med 284: 360–366. 1971.

[5] Quebec Medicare and Medical Services Withdrawal. Toronto, Canadian Medical Association, October 19, 1970.

That health is primarily a community or social rather than an individual concern.[6] A simple calculation from American mortality statistics[7] quickly corrects that false concept: 67 per cent of deaths in 1967 were due to diseases known to be caused or exacerbated by alcohol, tobacco smoking or overeating, or were due to accidents. Each of those factors is either largely or wholly correctable by individual action. Although no statistics are available, it is likely that morbidity, with the exception of common respiratory infections, has a relation like that of mortality to personal habits and excesses.

That state medicine has worked better in other countries than free enterprise has worked here. There is no evidence to support that contention, other than anecdotal testimonials and the spurious citation of infant mortality and longevity statistics. There is, on the other hand, a good deal of evidence to the contrary.[8, 9]

That the provision of medical care somehow lies outside the laws of supply and demand, and that government-controlled health care will be free care. In fact, no service or commodity lies outside the economic laws. Regarding health care, market demand, individual want, and medical need are entirely different things, and have a very complex relation with the cost and the total supply of available care, as recently discussed and clarified by Jeffers et al.[10] They point out that " 'health is purchaseable', meaning that somebody has to pay for it, individually or collectively, at the expense of foregoing the current or future consumption of other things." The question is whether the decision of how to allocate the consumer's dollar should belong to the consumer or to the state. It has already been shown that the choice of how a doctor's services should be rendered belongs only to the doctor: in the same way the choice of whether to buy a doctor's service rather than some other commodity or service belongs to the consumer as a logical consequence of the right to his own life.

That opposition to national health legislation is tantamount to opposition to progress in health care. Progress is made by the free interaction of free minds developing new ideas in an atmosphere conducive to experimentation and trial. If group practice really is better than solo, we will find out because the success of groups will result in more groups (which has, in fact, been happening); if prepaid comprehensive care really is the best form of practice, it will succeed and the health industry will swell with new Kaiser–Permanente plans. But let one of these or any other form of practice become the law, and the system is in a straitjacket that will stifle progress. Progress requires freedom of action, and that is precisely what national health legislation aims at restricting.

That doctors should help design the legislation for a national health system, since they must live with and within whatever legislation is enacted. To accept this concept is to concede to the opposition its philosophic premises, and thus to lose the battle. The means by which nonproducers and hangers-on throughout history have been able to expropriate material and intellectual values from the producers has been identified only relatively recently: the sanction of the victim.[11] Historically, few people have lost their freedom and their rights without some degree of complicity in the plunder. If the American medical profession accepts the concept of health care as the right of the patient, it will have earned the Kennedy-Griffiths bill by default. The alternative for any health professional is to withhold his sanction and make clear who is being victimized. Any physician can say to those who would shackle his judgment and control his profession: I do not recognize your right to my life and my mind, which belong to me and me alone; I will not participate in any legislated solution to any health problem.

In the face of the raw power that lies behind government programs, nonparticipation is the only way in which personal values can be maintained. And it is only with the attainment of the highest of those values—integrity, honesty and self-esteem—that the physician can achieve his most important professional value, the absolute priority of the welfare of his patients.

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[6] Millis JS: Wisdom? Health? Can society guarantee them? N Engl J Med 283:260–261, 1970.

[7] Department of Health, Education, and Welfare, Public Health Service: Vital Statistics of the United States 1967. Vol II, Mortality, Part A. Washington, D.C., Government Printing Office, 1969. p 1–7.

[8] Financing Medical Care: An appraisal of foreign programs. Edied by H Shoeck. Caldwell. Idaho. Caxton Printers. Inc.. 1962.

[9] Lynch MJ, Raphael SS: Medicine and the State. Springfield, Illinois, Charles C Thomas, 1963.

[10] Jeffers JR. Bognanno MF, Bartlett JC: On the demand versus need for medical services and the concept of "shortage." Am J Publ Health 61:46–63. 1971.

[11] Rand A: Atlas Shrugged, New York, Random House, 1957, p. 1066.

The preceding discussion should not be interpreted as proposing that there are no problems in the delivery of medical care. Problems such as high cost, few doctors, low quantity of available care in economically depressed areas may be real, but it is naïve to believe that governmental solutions through coercive legislation can be anything but shortsighted and formulated on the basis of political expediency. The only long-range plan that can hope to provide for the day after tomorrow is a "nonsystem"—that is, a system that proscribes the imposition by force (legislation) of any one group's conception of the best forms of medical care. We must identify our problems and seek to solve them by experimentation and trial in an atmosphere of freedom from compulsion. Our sanction of anything less will mean the loss of our personal values, the death of our profession, and a heavy blow to political liberty.

Mr. ROSTENKOWSKI. Thank you, Dr. Sade.

We now provide an opportunity for an interchange among the panelists. If any one of you would like to question or discuss a pertinent matter that you found in one another's testimony, we provide this opportunity for you to have that exchange and we will join you with our questions.

So are there any questions?

Dr. Rowland?

Dr. ROWLAND. Yes, I would like to say something about the right of health care. It is my belief that rights can't be granted by man; that rights are granted by God. If man can grant rights, he can capriciously take those rights away.

If we have a right to health care, then we also have a right to food, shelter, clothing, and all other things. And if this is a right, someone will have to pay for these rights. As someone has to pay for these rights, that means that money is going to have to be taken from some people to pay for these rights.

Do we have a right to take this money from people to pay for these rights?

Dr. GADDY. I would like to speak to that briefly.

I agree with the fact that right is a gift from God. The nature of "right," the quality of right, is thus defined by revelations of the nature of God and what he has done historically in respect to people's rights.

Now, after having said that I come out at a different point from the other two panelists. I think both in the ethics of Judeo-Christian morality and philosophical morality the right to life is affirmed, and a basic part of the right to life is the right to quality health care.

I don't see how you can separate the right to life from the right to health care because without health, life is jeopardized.

Mr. ROSTENKOWSKI. Dr. Crane?

Dr. CRANE. I hate to get into a religious discussion, but a question comes to my mind. I believe it also states in the Bible that our bodies are basically temples of God and if this is true, do I have the right to tell each or every one of you who is smoking that you are not allowed to violate the right of that temple for obvious reasons?

We then get into where does one right start and the other stop?

My right of extending my arm and fist stops short of Dr. Gaddy's nose.

Dr. GADDY. I agree, especially with the latter. The point I want to make is that every moral principle has to be seen in light of other moral principles; unless you make one absolute or adopt a series of absolutes. When I say health care is a right, I don't envision the imposition of health care on someone who doesn't want it. That is why as a part of my testimony I talked about the importance of freedom—freedom of choice for patients, doctors, and all involved.

A person has a right to be sick if that person wants to be sick. By the same taken, if a person is sick and desiring health care and can't receive it because of financial means, inaccessibility of services, or whatever, I think that person also has a right to get well if we have the capabilities to help that person get well.

Dr. Crane. I practice in the Bloomington, Ind., community. The natural population is about 25,000 and the university population increases it to 50,000. We had this issue raised in our community.

There was an allegation that 10,000 people in our community were not able to receive medical care of any kind. They didn't qualify for medicare, medicaid, or public aid; and they could not pay for medical care. We explored this in detail with the persons making the allegations.

We found they included in their statistics university students who fell into the "poverty level" in terms of their incomes, but we whittled it down to 250 families who legitimately did not have money to pay for medical care.

The medical community had alleged that they would always deliver medical care to anyone who came in and needed treatment regardless of their ability to pay. That didn't exactly prove to be true, because many of these patients came to doctors' offices and were indirectly turned away by the office personnel.

A health services bureau was set up through our community action program wherein the needy families were interviewed by community action people, to prove that they really were in that category. They were given a card so when they entered the doctor's office, they were assured of treatment even though they couldn't pay. The doctors had already agreed to give them whatever medical care they needed.

All they had to do was walk in and say, "Here I am. I need medical treatment" and the problem, for all practical purposes, has been solved. There is no one in Bloomington, Ind., who can't get medical care.

I cite this as a viable alternative. When we find out how many people really do not or cannot get medical care, it becomes a very small figure. Think in terms of your own experience, how many of you actually know someone who has been refused medical care of some sort or other.

Mr. Rostenkowski. Although doctor, in all the testimony we have had here I can think of only one instance where there was medical care denied, but we received testimony from various organizations that medical care is delayed so that it is almost fatal in some instances.

Now I think Congressman Crane had a colloquy with a witness yesterday with respect to the delaying of medical care. This is really what I see as a big problem.

You five gentlemen are closely in touch with people—how do you account for such a divergency of views as to whether or not this is a problem?

I would like just a capsule explanation as to why there is such a divergent view.

Dr. Crane?

Dr. Crane. I interned at Cook County Hospital in Chicago and saw a variety of medical problems. I have been a physician since 1962. In my practice as a physician—I can say I have actually saved only one life because I was there at a specific time and when a real medical emergency existed. Because I was there, at that moment, I saved a life.

I cite this example because I think many laymen view emergencies and feel it is life and death when, in fact, physicians know it is not life and death.

I might describe another personal experience. I play on a church softball team. I hit a fly ball and two outfielders collided, and both fell to the ground. I continued running around the bases and then went out and delivered medical care. There was another doctor on our team. We both walked toward the injured players while everyone else ran. The reason for our delay was if it was a real crisis, if they had had an acute hemmorrhage in the brain, there was no way we could have saved their lives. The opposing players were upset because it took a few extra seconds before we got there, because they thought it was a medical crisis.

My question to my medical colleagues is how many lives have they actually saved (surgeons excepted) because they were on the spot at a moment and truly saved a life because of their presence?

Dr. Sade. I have saved a few lives because I am a surgeon, and we see more acute problems that other specialists do; but, in general, I think your observation is correct. Medical care is in general not a life-saving process. It is a comfort-giving process, a pain-relieving process, a supportive process between doctors and patients.

We certainly don't give health; we don't give life; and, when people talk about health care as if not granting free health care to the citizens is the same as making them miserably sick for the rest of their lives, that is not true; people in general are healthy.

What doctors do when they intervene in the processes of illness is to allow a healthy body to heal itself. We don't heal anything. We can sew up a wound, but the natural processes of wound healing produce a solidly scarred and healed area. We provide a situation in which the body can heal itself.

Physicians don't give health and don't give life, and I think this is a very important concept that most people don't understand. They view health care as something absolutely indispensible to the health of 99 percent of the people in this country.

In fact, medical care is important to the health of 2 or 3 percent of people in the United States. The vast majority of people already are healthy and don't need that kind of health care. I want to make one other point about Mr. Rostenkowski's question about why we have such divergent points of view.

Some of us are collectivists and some of us are individualists. Those of us who are collectivists believe that it's perfectly all right to sacrifice the lives of some people to support the lives of others. It's perfectly all right to make it impossible for a health practitioner to practice freely, using his own mind and judgment, to put him into the strait-jacket that's provided by the pieces of legislation before you now. It's perfectly all right to sacrifice the intellectual and professional freedom of some in order to guarantee that others can have a sore throat examined.

I don't accept that notion. I think people can and want to take care of themselves. We don't need or want the kind of paternalistic guarantees that Government is trying to force on us now. I think the basic difference is between the points of view you have heard this morning is a fundamental philosophical one, with different answers to the question of whether it is ever proper for society or government to sacrifice the lives of some human beings to the desires of others.

Reverend LIPPHARDT. Two comments, if I may: One, on the notion of health care as a right. To the gentleman furthest to my right, I am in agreement, it's not so much a right that is legislated but something that is guaranteed by legislation as are the other rights guaranteed by the Bill of Rights.

Those rights are not legislated. They are guaranteed by legislation. and we feel that health care is a corollary to life itself and needs to have some guarantees. But to a point mentioned earlier about the availability of health care in many of the larger areas where there are larger numbers of physicians, a better ratio of physicians to population is needed in West Virginia. Forty out of our fifty-five counties are designated as health service scarcity areas by reports of community health service and the National Health Service Corps. Eight counties in our State have no hospitals and no clinics registered with the department of health. Doctors in West Virginia are responsible for 28 percent more people than the average American doctor, and that includes in that statistic 242 residents and interns at the West Virginia Medical Center and the Charleston Area Medical Center.

Twenty-five percent of West Virginia's doctors are now over 60. This is speaking to the point of increasing the number of personnel available and also facilities available. As far as the divergency of views, I am in agreement with the individual versus the collective notion.

I come out of a Judeo-Christian arena which says we are all brothers and sisters. Whereas we would care for other members of our family we ought also to care for all human beings since we are all of the family of God despite our social and political backgrounds.

Dr. GADDY. I want to speak to the question about divergent points of view. We come at this issue, like any other, from where we are, and that colors the way we see it.

Obviously, some of the panel members here look at the matter of health security from the perspective of a medical practice. They see patients coming in and out of their offices who are being treated, getting well, and functioning as well as they can function. They see health care being delivered in a satisfactory manner as far as their perspective goes.

My perspective is colored by the fact that I have had the experience of being in a waiting room with a victim of an automobile accident and seeing that person almost go into shock because of a lack of attention. Delay was caused by debate over who was going to pick up the bill for the care of this individual.

I had one person suggest to me on one occasion that we take a person into the emergency room of the hospital and leave the person, walk out, not identify who we were, and who the person was; and, in that way, the person would be sure and get medical treatment. Whereas, so the suggestion went, if we stayed there, there would be a debate on whether or not the person could pay.

I have had the experience in a local congregation of going around to various members and trying to raise enough money to guarantee that a member of one particular family in the community could enter the hospital and receive health care. I have found, as I am sure these gentlemen have, the kind of anxiety that arises in people when they have a disease that has to have certain therapy the cost of which is prohibitive from their point of view. So I come at the matter of national health security from a different perspective, and I think that explains the divergent points of view.

Also, it's one thing for us to define crisis in this room. It's another thing for a person who is ill to define crisis. I understand that people may not at all times be as sick as they would lead us to believe, but for sick individuals, the lack of adequate health care is a crisis.

If I am not hurting, I don't have a right to determine when or how that man who is hurting is going to yell.

A third thing. I would hope rather than consistently getting bogged down in all of the divergent points of view, that we can see if there is any common ground on which to stand. What I would suggest at this point in discussions of health care legislation is that we need to take our focus off of the end results of particular proposals and consider the moral foundations upon which we should base any and all actions.

Members of our society—medical professionals and church people—should be asking, "what are our ethical responsibilities relating to the health care of all people?" I would hope that at this point we can find some fundamental areas of agreement.

Mr. ROSTENKOWSKI. We are hoping in this subcommittee, Doctor, that when we are through with receiving testimony this subcommittee may come to that point.

Mr. Duncan may inquire.

Mr. DUNCAN. I would like to ask Dr. Gaddy a question.

Are you from Nashville?

Dr. GADDY. Yes, I am.

Mr. DUNCAN. You say you cannot speak for the Southern Baptist Convention, but they do take positions on matter such as these.

If they had taken a position on H.R. 21, then you could speak for them?

Dr. GADDY. Not really, because the convention cannot determine what any one Southern Baptist is going to say.

Mr. DUNCAN. They do take positions on legislation.

Dr. GADDY. The messengers to the annual convention take positions.

Mr. DUNCAN. They did not take a position. In fact, they did not even entertain it.

Dr. GADDY. A few years ago they entertained a resolution on medical security, health care, and medical costs, and that was referred to the Christian Life Commission of which I am a staff member.

Our testimony was not to the point of arguing one particular plan over another, but of affirming the moral responsibilities of national health care legislation.

Mr. DUNCAN. These individuals that you are talking about, what hospitals were involved? These examples that you have given.

Dr. GADDY. One of the hospitals was in Memphis, Tenn. One of the hospitals was in Seymour, Ind.

Mr. DUNCAN. Would you give the names of the hospitals?

Dr. GADDY. Yes, if I can remember them. The hospital in Memphis, Tenn., was a Baptist hospital.

Mr. DUNCAN. When was that?

Dr. GADDY. That was in 1963.

Mr. DUNCAN. Would you give us the name of the person involved?

Dr. GADDY. No, sir. I don't believe I will.

Not for the record. I will off the record.

Mr. DUNCAN. You brought it into issue. Why can't you give the name?

Dr. GADDY. I really would like to protect the privacy of the individual. I don't have a thing to hide here.

Mr. DUNCAN. I know you don't. That's why I am asking the name of the individual.

Would you supply that?

Dr. GADDY. I can provide the name of the individual.

Mr. DUNCAN. What about Seymour, Ind.?

Dr. GADDY. I can provide the name of the deacon that went with me to the hospital. The individual was a young man we picked up in an automobile accident.

Mr. DUNCAN. You mentioned two incidents. Where were the others? Did you find them in Nashville, also?

Dr. GADDY. I mentioned two instances. I mentioned another instance in which there was a recommendation from a fellow minister of how to get treatment. He told me of a way this had been done in the past. I can't document that.

Mr. DUNCAN. He just suggested that?

Dr. GADDY. Yes. I never took that suggestion seriously because I thought it was an irresponsible way to deal with the problem.

Mr. DUNCAN. Those were the only two that you know of?

Dr. GADDY. That is right.

Mr. DUNCAN. 1963, and when was the one in Indiana?

Dr. GADDY. That was 1967 or 1968.

Mr. DUNCAN. That was before the days of medicare.

Dr. GADDY. Yes. The people in question would not have been covered by medicare.

Mr. DUNCAN. Now, what happens in Nashville—I know what happens in Knoxville, but what happens in Nashville if a person is involved in an automobile accident?

In Knoxville the individual is taken to the emergency room and he is taken care of whether he can pay or not because the city of Knoxville has indigent hospital care for people who cannot pay. I presume this is the same in Nashville.

Dr. GADDY. I believe, Mr. Duncan, that is correct. I have not had personal experience there because I am out of a local pastorate, and I have not had that experience.

My last local pastorate was in Louisville, Ky. That was the case there. If a person was in an accident he was taken to a general hospital. Some provision was made.

Mr. DUNCAN. Also, if he is in a hospital and he is indigent, the city of Nashville pays the bill. Our city spends almost $4 million a year for indigent care; and I have never known a person in my city that needed hospital care that could not pay for it and could not receive it.

Can you say that about Nashville?

Dr. GADDY. No, sir, I cannot.

I just don't know.

Mr. DUNCAN. Do you know what H.R. 21 would cost if put in effect?

Dr. GADDY. I know what various figures are.

Mr. DUNCAN. What will it cost?

Dr. GADDY. One of the figures is $108 million, I think.

Mr. DUNCAN. $108 billion.

Dr. GADDY. $108 billion, I'm sorry.

Mr. DUNCAN. I used to have that problem, too.

Dr. GADDY. It is difficult to talk about money in those amounts.

Others have said as low as $80-something billion. That is why, Mr. Duncan, I am not prepared to get into a discussion of those kinds of specifics.

Mr. DUNCAN. But you do recommend it regardless of what it costs?

Dr. GADDY. I did not.

Mr. DUNCAN. You do recommend H.R. 21?

Dr. GADDY. I did not recommend any specific legislation.

Mr. DUNCAN. Dr. Lipphardt, what do you think it could cost?

Reverend LIPPHARDT. The estimates I have are $108 billion to $116 billion.

Mr. ROSTENKOWSKI. We have had testimony here that it would not cost any more money than we are spending now.

Reverend LIPPHARDT. 1974 cost was $104 billion, which was a 10-percent increase over 1973, and I think I could stand confident in saying that the 1975 bill would be somewhat higher than $104 billion.

Even if the cost of H.R. 21 is as high as $116 billion, the inclusion of the many more people able to have health care services, would, in my estimation, be worth the cost.

Another thing to raise, Dr. Fein, I believe, is his name, from the Harvard or Boston Medical School has said that it is not like approving money for some new thing. We are already paying for health care services. The money is just going to be transferred.

It will increase some costs.

Mr. DUNCAN. But you are going to go through taxes this way.

Reverend LIPPHARDT. Yes.

Mr. DUNCAN. You have also said in your statement, and I have taken my time, but I would like to ask one more question. On page 3, you say:

> Our Board believes, in concurrence with the General Conference Board, that the lack of prepaid group practices or health maintenance organizations which provide comprehensive care to an enrolled population on a fixed annual basis is the greatest existing arbitrary limit to freedom of choice for patients and physicians.

Well, in most HMO's the patient doesn't have the freedom of choice. He just must take the physicians on the staff of HMO's. Are you aware of that?

I don't quite understand your statement where you say you should have freedom of choice. I applaud you for that part of your statement.

Reverend LIPPHARDT. The point I was making primarily there was for the freedom of choice that that would also give physicians as well as the individual consumer.

Mr. DUNCAN. Thank you, Mr. Chairman. My time is up.

Mr. ROSTENKOWSKI. Dr. Sade?

Dr. SADE. Can I just make a brief comment about the question of costs? Various departments of government make estimates of how much these bills are going to cost. Traditionally, they grossly underestimate the amount that they cost. Looking at medicare and medicaid, their costs were grossly underestimated.

However, an objective study was recently published in the New England Journal of Medicine from the Rand Corp. It looked at different types of national health insurance and the effects they would have on total national expenditure for health care. A comprehensive bill of the Kennedy-Corman type will cost, by their estimate, about 11 percent of the gross national product.

Right now we are spending just a little over 8 percent of our gross national product for health care. At the 11-percent cost of a comprehensive bill, figuring at a current gross national product of somewhat over $1.3 trillion, the total expenditure for health care will be on the order of $140 to $150 billion. I think that is probably a little closer to the reality of what the cost would be than the other estimates we have gotten from Government sources.

Mr. BURLESON. Mr. Chairman, I don't have any questions. I simply want to compliment you and the staff on putting together a tremendously interesting panel. You had an interesting one yesterday, but I think this is an outstanding group. I like to listen and have enjoyed the philosophical discussions, and I commend you.

Mr. ROSTENKOWSKI. Thank you, Mr. Burleson.

Mr. Cotter?

Mr. COTTER. I have no questions.

Mr. ROSTENKOWSKI. Mr. Crane will inquire.

Mr. CRANE. I welcome this distinguished panel today.

I have just a couple of questions, and it gets back again to the philosophical discussion, because we have heard a great deal of testimony on this committee on this point that was touched upon about health care being a right; and I was most appreciative of the fact that Dr. Sade focused in on this point because he said it more eloquently than I have in the past.

I think there is a confusion that you clergymen have on this point as I would perceive it as what I feel is a Christian perspective, too. I was taught, brought up in the Methodist Church, that I have a moral obligation to tithe and I have endeavored to tithe all my life. I was taught that in addition to that I have a personal obligation to help those less well off than myself.

But I was never taught that I had a right to spend his, a doctor's, life philanthropically according to what my teaching and upbringing told me. I think when you get into suggesting that somehow there is an unalienable right that people have to health care, what you are really saying is they have a right to lay claim to another person's life.

I cannot think in Christian teaching of anything that justifies my right to lay claim to another person's life. Can you give me a Scriptural justification for that kind of claim?

Reverend LIPPHARDT. You are asking me to proof text, and I am not exactly prepared to do proof texting, but I will respond.

The Government or no one else—you know, if you were going to maintain that position—would have the right to put a tax on me for defense spending as well as health care; and, if I had to make a judgment on which tax or funding that I would deem to be of greater human interest, it would be health care.

Mr. CRANE. Let me raise a question here with you on that point because you get back to, I think, some pretty profound assumptions upon which Government is organized in the first place.

And, according to the Declaration of Independence, for example, they start out with the premise that there is a God; we are created in His image; and, as such, endowed with those inalienable rights to life, liberty and the pursuit of happiness.

I think Locke said it better: Life, liberty, and property, because property includes ideals of responsibility and what-have-you.

When men join together in a social compact, again harking back to those promises in the Declaration, it is to make themselves more secure in the possession of their God-given inheritance. So national defense is the first and foremost obligation.

It is the police power of the local government to prevent trespass. It seems to me when you start suggesting that some individual in society has a right to those conditions—somebody yesterday said that the maintenance of health, and I think it was in your testimony, Mr. Lipphardt, that you indicated that health care should be comprehensive including physical, dental, mental, and emotional fields of practice and should focus on practices of treatment as well as rehabilitation.

I asked Mr. Meany when he was down here testifying how far did he want to carry that notion? Did that include a right to food on demand? Did that include a right to housing, fuel, transportation? He indicated initially he thought it did, but he stopped short of entertainment.

Dr. Crane, a psychiatrist, might argue the case very persuasively that within this comprehensive rate you are discussing to emotional well-being, to mental equanimity, that, in effect, you are suggesting we have a guaranteed God-given right to happiness.

Is that your reading of the Declaration of Independence, that we have a right to happiness?

Reverend LIPPHARDT. Yes.

Mr. CRANE. It says a right to pursue happiness. That means guaranteeing my freedom of choice and action as an individual.

I cannot understand that anyone can claim he has a God-given right to happiness. I have a right to pursue happiness short of trespass.

Reverend LIPPHARDT. Yes; and you also have a right to be as unhappy as you wish to be. I do not think the right to be happy negates the right to be unhappy, or the right to pursue happiness negates the right to pursue unhappiness.

Mr. Crane. This is necessarily the point. You must necessarily be infringing on other people's rights. If you begin to say, I have a right to be happy.

You theologians of all people should be the ones to teach a person that that quest is a personal thing. It involves a relationship between the individual and his God. It is spiritually based. It is not in the material world.

Dr. Gaddy, in your testimony you touched upon health care and said health is in some respects the gift of God but health care in our society is a moral right.

How about Job? Did the devil inflict that on Job?

Dr. Gaddy. Do you want to get into a theological interpretation or an exegetical interpretation of Job? Also, there is a difference between the character of Job in the prolog to the book and in the body of the book.

Mr. Crane. Are you suggesting that God, who is omniscient and could make us totally healthy if he desired to do so, that God has decreed us that we should be healthy?

Dr. Gaddy. I don't think there is any doubt of what the will of God is: that people be whole individuals.

Mr. Crane. Spiritually and physically, but I would think you would not reject that notion that he is omnipotent.

Dr. Gaddy. That is right.

Mr. Crane. So why aren't we all whole?

Dr. Gaddy. Theologically, we can talk about sin as a reason. We can also talk about freedom. Because of personal freedom, I have the right to step out in front of a car if I so desire. When I cross the street out here, I could step in the path of a moving car and get hit. That doesn't mean God wanted me to step out in front of a car. I chose to do so. But I have the personal freedom to do that if I want to.

Let me say at this point, that somehow what I said about freedom has not been heard. I keep hearing the use of the word "force." I am not talking about enforced health care.

I am talking about the right of health care.

Mr. Crane. You are talking about enforced health care because that is precisely the point. When you say every individual has a God-given right and an inalienable right to health, you are saying that I have a right to lay claim to any physician's life who has that special competence and expertise to treat whatever my disorders are.

All I am saying is I cannot find where in the Judeo-Christian ethic any principle of morality, any justification to lay claim to another man's life or even a portion of it.

We called that slavery a century ago, but I think there are subtle continuations even in relatively free societies of that when you say because all of you out there vote to take a portion of my life and my expertise and my talents, therefore, you have a right to those talents.

What if I say I'm walking out on strike? What if all of the physicians walked out on strike? How do you go about implementing that right? At the point of a gun?

Dr. Gaddy. I do not see that as slavery. I see it as social responsibility.

Mr. Crane. That's a personal thing. I would agree with you. I think they have the social responsibility, too. I think the overwhelming majority of physicians try to exercise it with respect to the needy, even if they aren't going to get paid. Sure, there are bad apples in that profession. There are bad apples in your profession and my profession, too. I think at some point you are talking about collective force to get those individuals who have the expertise to provide it to somebody else whether they want to or not so if you are appealing to them and say they have a moral responsibility——

Dr. Gaddy. But I would defend their right not to treat someone.

Mr. Crane. How does another person enjoy his right, if he has a right to health?

Dr. Gaddy. Because I believe we have the capabilities to develop a health care system in which there will be enough of the kinds of people we are talking about that will be glad to treat a person. This is exactly what I heard Dr. Crane saying had happened in his hometown.

I think there are enough of those kinds of people that that can be done. I am a firm advocate of individual freedom, but I don't think it is possible in society to have individual freedom apart from social responsibility.

Mr. Crane. Dr. Gaddy, unfortunately my time is expired, and I would agree with you wholeheartedly. I think to talk about freedom and irresponsibility is a contradiction in terms.

I think we struck now a common denominator that you thought we might try to explore. That is to get people to address honest problems that even the physicians would acknowledge we have in our health care system. That changes the dimensions of the debate to figuring out what system is best calculated to do this.

I would argue when you resort to force and dictation to get performance out of people and I have seen it in the British system. You have a total breakdown of responsibility, of accountability; the doctor is working for the Government, no longer for the patient. The patient has no choice in the selection of his physician.

Everybody could care less about the system because they think someone else is paying for it. I think there you get a total erosion of personal character, personal responsibility, personal accountability. Whereas, a system that's based upon to the maximum degree volunteerism, choice and charity and the acceptance of philanthropy, a doctor who says you can't pay but I recognize your need and I will treat you—any system that recognizes that is most consistent with your philosophy and beliefs.

Dr. Rowland. May I make a comment to accentuate what Mr. Crane has said.

We have problems in medical care. There will always be problems in medical care. I don't know of anything that works a hundred percent of the time, but free men in a free society can better settle these problems than the Government.

Dr. Crane. I might also comment, I mentioned our health services committee in Bloomington, Ind.

We have just had a meeting with the people who are doing the processing part of this. It was their statement that we have not had a single complaint where an individual has not received medical care and adequate medical care.

Mr. Rostenkowski. I wish to thank you.

I will echo the remarks of my colleague, Mr. Burleson. I will make one observation: You may have hit a home run in baseball, but you don't do a good job of helping your brother with the cigarettes.

I have a right to clean air, too; isn't that true?

Dr. Crane. That is right. In psychiatry, we have concluded that there isn't a great deal we can do with chronic cases.

Mr. Rostenkowski. Will Dr. Bryan, Mr. Samuel and Dr. Christmas, Dr. Ball, Mr. Hanson, Mr. Clark, and Miss Nunes please come forward?

PANEL CONSISTING OF J. ELDER BRYAN, M.D., DOWNEY, CALIF.; F. M. BALL, M.D., CHARLESTON, S.C.; JUNE J. CHRISTMAS, M.D., VICE CHAIRPERSON, AND HOWARD D. SAMUEL, SECRETARY, NEW YORK STATE COMMITTEE FOR NATIONAL HEALTH SECURITY; ROY STEVENS, NEW ENGLAND DISTRICT DIRECTOR, DIANE NUNES, CHAIRMAN, MASSACHUSETTS COMMITTEE, AND EDWARD C. SIMONE, REGIONAL COORDINATOR, NEW ENGLAND COMMITTEE ON NATIONAL HEALTH SECURITY

Mr. Rostenkowski. I want to welcome this panel. Before we begin the testimony, I would like to make an observation. We will have each of you testify and make your presentation. Then, at the conclusion of that, we have an exchange between those of you who feel you would like to comment on someone else's testimony. Then the subcommittee members will ask questions.

At this time I would like to introduce a longtime friend of mine, our good friend, Congressman Del Clawson.

STATEMENT OF HON. DEL CLAWSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. Clawson. Thank you. My purpose is to introduce a longtime friend of mine and member of my constituency from my hometown in California, Dr. Bryan. He is a member of this panel. I want you to know, Mr. Chairman, he has been interested in this field for a long time. Just last week I introduced a bill that was prepared by Dr. Bryan in the health care field.

He goes back many years, I think some 10 or 15 years. I think he is well qualified to make this presentation particularly in his field of expertise. I am happy to welcome him to the panel.

Mr. Rostenkowski. Thank you. We will be looking forward to hearing Dr. Bryan, as well as the other witness' testimony. Dr. Bryan, you may begin.

STATEMENT OF J. ELDER BRYAN, M.D.

Dr. Bryan. Chairman Rostenkowski, my statement will vary a bit from the written statement but in essence it is the same.

Mr. Rostenkowski. We will include your entire statement in the record.

Dr. Bryan. It is a great honor to be permitted as an individual to speak for 220 million people. The idea for this bill, H.R. 10562, was germinated 20 years ago when Dr. Richard Halverson, now of the Fourth Presbyterian Church, Washington, D.C., dedicated my office to the care of patients in the name of the Lord; was born about 20 years ago when a patient with no insurance was having difficulty meeting his medical bills, and I recommended he ask Congress for a simple tax deduction for his expenses.[1] It started to crawl 15 years ago with an explanation to our church that St. Paul really meant it when in his first letter (chapter 5) to Timothy [2] he told him the needy were to be cared for by themselves or their families and only when they failed the church was to take over—he never mentioned the government. It grew when Representative Del Clawson asked that this completely voluntary concept of insurance and medical care with tax credits and deductions be put on paper.

It is generally conceded that the present process through which citizens obtain medical care can be very costly for those who are not covered by group or government insurance. The Congress has wrestled with several possible solutions.[3] Most solutions, it would appear, are much more costly than our Federal and State treasuries can afford.[4] Therefore, the essential question remains—"How can we use our current resources in order to extend sufficient medical care to the greatest number of citizens, at the lowest possible cost?" In our brief explanation of this question we might benefit from an analysis of the shortcomings of the current system of medical assistance, as it functions through the institution of welfare. We'll conclude with comments as to the features of bill H.R. 10562, which we propose should assist in correcting the malfunctions of the current system.

In our past efforts to provide medical assistance to those in need, we seem to have been victimized by our own good intentions. Some years ago, our Government recognized a need to provide such assistance to millions of citizens. Subsequently, we built and staffed a bureaucracy which now costs more to maintain than is economically feasible. A disproportionate amount of tax dollars are wasted in administration of the system while the payoff in the quality of health care diminishes.[5] In building the wasteful welfare structure, we have ignored more appropriate social channels through which medical care could have been obtained more efficiently.[6] It seems we have operated upon faulty assumptions in expecting Government agencies to deal with the medical needs of the Nation.

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[1] I.R.S. Code 1954 sec. 3(a) sec. 213(a).

[2] I Timothy 5:1–10.

[3] H.R. 1. H.R. 21. H.R. 6222, and all others except H.R. 3328 and H.R. 10562.

[4] Sen. John Tunney opposed to N.H.I., Los Angeles Times, Aug. 6, 1975.

[5] Audit of California Medicaid 1974.

[6] A table follows:

Mode of "donation"	Donors cost		Net to needy
	Congressman Del Clawson	H. L. Wells, Northwestern University	
Direct	$100	$100	$100
Charitable organization	110	108	100
City of county tax	133	125	100
Local bond issue		175	100
State tax	200	200	100
Federal tax	400	300	100

Compelled charity, through taxation, and administered by inefficient social welfare agencies is failing to meet the current challenge. We have dramatically underestimated the charitable nature of the American people when they can determine through community charitable organizations where their assistance will be of greatest effect.[7] Those in Government seem to have assumed that Americans would exclusively pursue selfish interests unless coerced by general taxation. Elected representatives felt that they would temporarily extend the hand of "Big Government" to uplift citizens-in-need to the plateau of self-sufficiency. We seem to have made many costly miscalculations.

We have underestimated the desire of Americans to act as good neighbors. By taking on the functions formerly performed by concerned citizens and private charitable organizations, the Government has denied us the incentives for many acts of kindness between neighbors. Although it was assumed that Government would be more efficient in its administration of charity, the opposite has been the result. Instead of being a temporary vehicle in the lives of those affected, the welfare line has become the final destination. As a cruel result, the welfare system has slowly and steadily stolen the dignity from those people it was determined to help.

We doctors shouldn't be asked to stitch a wound with a pen, nor should we fashion a bandage from paper. The Government, however, in sponsoring the wasteful welfare mill has forced doctors and our highly trained staffs to leave the full time practice of medicine for the burdensome practice of bureaucratic accounting. It is estimated that 25–30 percent of the time of doctors' staffs is thoroughly wasted with nonpurposeful paper shuffling. Needless to say, the diversion of medical energies is paid for dearly in money, doctor-patient relations, and in the quality of medical care.

Various findings demonstrate for us that our current system of providing medical care through independent doctors rather than social welfare agencies is the most effective method available.[8] [9] This bill, H.R. 10562, when enacted would provide medical insurance for our citizens which would maximize the benefits inherent in the practice of medicine by independent doctors. It will also liberate the energies of practitioners currently burdened with the processing of welfare claims. It will give people of financial stability a socially desirable way of expressing charitable intentions by providing tax deductions. It will allow vulnerable citizens, at this time unable to join group medical insurance plans, the financial means to do so, through a simple system of tax credits.

Our bill, H.R. 10562, we sincerely hope, will provide a simple mechanism through which the best health insurance coverage will be available to the greatest number of people at the lowest possible cost, and it will do so in a manner that is consistent with the stimulative and productive aspects of private enterprise.

Just as unions fought 40 years ago for the freedom of the laboring man from the oppressive company housing and company stores, so you and they should work for freedom from the restrictions of company insurance which ties a person to a job and leaves him without insurance if he loses his job or has to move for health reasons.

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[7] Red Cross, World Vision, Food for the Hungry, Shriners Crippled Children and a thousand other charities.

[8] Cost of Standard Medical Services Under Alternative Delivery System; Community Profile Data Center Technical report, October 1972, Department of HEW.

[9] Policy Options and the Impact of National Health Insurance, Rand Corp., Dr. Joseph Newhouse, New England Journal of Medicine, 1974, vol. 290, No. 24.

There is nothing compulsory about this bill. We know nothing is perfect. If there is a weakness in it, one would have to say it is in the area of the coverage of the needy and indigent. Most Americans, hopefully, have not had their hearts hardened or become embittered by coercive taxation to the point where they would be like the Levite or the priest and pass by the needy. Fortunately, most of us fall in the class of the good Samaritan who gave his medicaments, his coat, his donkey, his money, and his pledge to pay more.[10]

Jesus Christ said, "Mind yes, there will always be some among you who are poorer than others." [11]

The philosophy of this bill, H.R. 10562, is summed up in a statement by the Talmudic philosopher Maimonides: "The noblest charity is to prevent a man from accepting charity, and the best alms are to show and enable a man to dispense with alms." [12]

Practically speaking, bill H.R. 10562, allows:

(1) A refundable income tax credit to anyone buying basic health insurance for his own use.

(2) A reasonable exclusion or deductible of medical expenses for tax purposes; then

(3) A straight deduction from gross taxable income for any additional medical expense.

It encourages:

(1) States to purchase health insurance for the indigent through the private insurance industry; and

(2) It encourages everyone to care for his own needy or indigent fellowman by giving the donor a charitable tax deduction for all moneys donated to purchase medical care for those in need.

I thank you.

[The prepared statement and statistical table follow:]

STATEMENT OF J. ELDER BRYAN, M.D., DOWNEY, CALIF.

SUMMARY

I. Amend the Internal Revenue Code of 1954 to:

A. Provide a refundable income tax credit. For the purchase of basic health insurance policy or plan.

B. Provide a reasonable exclusion or deductible (to discourage overuse).

C. Provide a straight deduction from gross taxable income for:

1. Any additional medical expenses.

2. Charitable gifts to purchase for the needy or indigent.

a. Basic health insurance policy or plan.

b. Additional health care.

II. Amends the Social Security Act to:

A. Encourage every State to provide medical care to the needy and indigent through private insurance plans or policies.

III. Private Insurance Industry does administer their policies for a fraction of the cost of administering government plans.

A. Tax credit encourages:

1. Those not already covered to purchase own insurance rather than use Veteran Administration Hospitals:

a. 71.6% of VA Hospital Admissions were non-service connected in 1974.

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[10] St. Luke 10:30–35.
[11] St. Matthew 26:11.
[12] Maimonides, Talmudic Philosopher.

b. 15.7% of the Admissions had both non-service and service connected diagnoses in 1974.

c. 28.9% of out patient visits were for non-service connected diagnoses.

2. Those who need to change jobs to purchase own insurance.

B. Reasonable exclusion discourages overuse:

1. Dr. Harry Schwartz—Case for American Medicine.

2. Dr. Joseph Newhouse—Rand Corp. Financing Medical Care.

IV. Charitable tax deduction for aiding others:

A. Tax benefit to donor.

B. Tax loss to government is less than medical care would cost.

C. Recipient receives same medical care as all others with similar policy.

STATEMENT

This bill when enacted will place every American individual or family in the mainstream of medical care on a voluntary basis. They will be allowed, if they so desire, to purchase their own health insurance for which they will be using their own money for one of the basic needs—food, clothing, shelter and *health*. For this, they will receive a tax credit. This could represent 100% of the low tax payers tax and only a fraction of a % of the high taxpayers tax.

Several of the largest health insurance providers have told me the best basic health insurance policy could be made available to all at about a 5% increase in cost to all—if all insurance companies accepted all applicants at the same time and could pool their bad risks. The chronically ill and so called uninsurables actually are a very small fraction of the total population. Pooling bad risks would take care of all.

Reports by the Rand Corporation and the Department of Health, Education and Welfare have very convincingly shown the least expensive care is through the local independent doctor. It is best paid for by a basic health insurance policy which has a reasonable exclusion (deductible) to discourage overuse and keep it actuarially sound and then has an 80/20 co-payment for the same purpose to a reasonable maximum and then 100% coverage.

Congress will be doing its part to help return this country to fiscal responsibility by allowing each person or family the opportunity to care for himself. The insurance companies in cooperation with the state, can voluntarily work out the other problems.

An example: If all could purchase good basic insurance at a standard rate at specified times each year (June and July) and a motorcyclist chose not to purchase until after he had a spinal cord injury—he would get his tax credit for his standard rate portion but would receive no credit for waiting until he was a high risk. The next year by signing up during sign-up time he would get the standard rate and whole tax credit.

It is the natural and accepted principle in this country to help those in need. However, over the past 40 years this has become increasingly difficult. In all cultures and even in the animal world one stores up for the time of need and helps those less fortunate. Taxes are so confiscating now that it is difficult for many people to provide for their daily needs let alone save for the future or for an emergency. A catastrophic health problem also becomes a catastrophic financial problem which spreads over into food, clothing and shelter. Just as soon as the basic ground work can be laid by Congress passing and the President signing H.R. 10562, we will be well on our way toward reducing taxes, reducing government waste and helping all reduce their out-of-pocket cost of medical care.

After H.R. 10562 is passed the States will be lowering their administrative costs by turning the health care of the needy over to the private insurance industry. The people of this country through charity will see that it is less expensive to donate to medical care and receive a charitable deduction than to pay taxes.

The cost of administering the Medi Cal program in California is 52% of the allotted tax dollar. The private insurance companies have to limit their administration costs to 9–13% to remain competitive. A study by HEW has shown the least expensive comparable medical care to be in the office of the independent practitioner. Comparable care in a Veterans Administration Hospital costs the taxpayer 6 to 8 times as much as it does in the local community hospital. Most patients with non-service connected disabilities would prefer to stay in their own locality. They could do this with their own insurance.

Page 8 "(g)" (2) "(A) and (B)." The following is my illustration of how I feel this should work. If it doesn't and can't be corrected simply, leave it as it is and then amend it later.

Gross taxable income	Exclusion for medical expenses to $500	Allowable medical expense deduction [1]	Taxable income	Tax from IRS table	Credit for cost of basic insurance	Tax due	Tax refund	Negative income tax
$4,300	0	0	$4,300	0	$600	0	$600	0
$4,300	$500	0	4,300	0	600	0	600	0
$4,300	500	$2,000	2,300	0	600	0	600	$2,000
$8,200	0	0	8,200	$607	600	$7	0	0
$8,200	500	0	8,200	607	600	7	0	0
$8,200	500	2,000	6,200	271	600	0	329	0
$20,000	0	0	20,000	4,380	600	3,780	0	0
$20,000	500	0	20,000	4,380	600	3,780	0	0
$20,000	500	2,000	18,000	3,820	600	3,220	0	0

[1] Based on an insurance policy which also has a $500 exclusion and then 80/20 copayment to $10,000 then 100 percent coverage.

Mr. Burleson [presiding]. Thank you, Dr. Bryan.

Dr. Ball, you are next and we will hear you.

STATEMENT OF F. M. BALL, M.D.

Dr. Ball. I thank the subcommittee for permitting me to express my views about national health insurance and about the bills relating to this subject now before the committee. Few private doctors have been given a chance to appear and speak out and I appreciate and welcome the opportunity.

I am F. M. Ball, a Charlestonian and a physician engaged in private family practice limited to internal medicine. I have been in solo private practice for the past 27 years in South Carolina after finishing residency training in 1948.

I shall discuss my personal observations about national health insurance from the viewpoint of a private practitioner under the following titles:

1. Cost, Inflation, and Socialism.
2. Destructive Aspects of Proposals for National Health Insurance.
3. Present Plans and Mechanisms for Rationing Health Care under National Health Insurance.
4. A Critique of H.R. 10028.

I do not appear here to protect a personal financial interest in the practice of medicine. I do not anticipate that physicians and surgeons, without whom no national insurance scheme can function, will find themselves seriously embarrassed financially or will suffer great monetary loss under national health insurance. Nor do I intend to abandon my profession and my patients even if a very restrictive socialistic measure is approved by the Congress. In that event, unless prohibited by law, I would continue to practice medicine outside the national health scheme and I would expect to make a living. I would remain a private physician and I would resist becoming an agent of the central Government and the Secretary of Health, Education, and Welfare.

I represent at this hearing only myself and my patients, the vast majority of whom vocally oppose further Government intervention in the field of their medical and hospital care. After being victimized by rising taxes, spiraling inflation and paralyzing regulations generated for the past 40 years by a fiscally irresponsible Federal Government, they find it unreasonable to accept the promise that the seizure of a monopoly over their health care or control by the Federal bureaucracy can bring reduced costs and better quality.

I appear in opposition to all the forms of health insurance before this committee including H.R. 10028, cited as the "Catastrophic Health Insurance and Medical Assistance Reform Act," by Mr. Joseph Waggonner. I single out Mr. Waggonner's bill for two reasons. First, because his bill, which I consider the least noxious of those that this committee must consider, identifies important problems in today's financing of medical and hospital care but suggests the wrong solutions and therefore merits protest and criticism. Second, because during World War II, when I was medical officer aboard the ancient destroyer-minelayer, U.S.S. *Pruitt* (DM–22), Mr. Waggonner was my superior, the executive officer of the ship, and far and away the finest officer under whom I served during my 2½ years active naval career. We have not met again in 30 years. We have come full circle.

COSTS, INFLATION AND SOCIALISM

During World War II, both Mr. Waggonner and I, and others of you who served in that frightful conflict, believed, and I think we still do, that we were a part of a great effort to destroy the cruelty and slavery of dictatorship and to preserve for ourselves and our children the liberty guaranteed by our Constitution and continued freedom from governmental restraint and regulation; regulation and restraint so characteristic of the very political systems of the nations which had set out to destroy us. Even then, 30 years ago, in bull sessions in the wardroom of the *Pruitt*, we had begun to discuss the inescapable future struggle of Christendom and the free nations of the West with the tyranny and terror of the conspiracy of socialistic communism led by its criminal psychopaths. We had begun to wonder then whether, when we had won the war, we would be left in peace to live out our lives in a nation where men could remain free and unhampered by Government control and interference.

A vast and frightening change in our national political philosophy and in our Government has taken place since those inspiring days. Now we find ourselves smothered and restrained by Government to the point of suffocation. Regulations issue from Washington that become ever less tolerable and begin to suggest the edicts of an elite proclaimed to inferiors. And all of this allegedly to promote our welfare and security, whether we like it or not. All these good things are forced upon us at such enormous expense that unimaginable deficits mount and the rate of inflation can no longer be predicted, much less controlled.

Inflation is caused by the unchecked deficit spending of an irresponsible government. This has been true since the recorded history of civilization and has been elegantly described recently by Dr. W. Philip Gramm, professor of economics at Texas A. & M. University, in his paper "Inflation: Its Cause and Cure." This is a fact of life, not easily recognized, it would appear, by politicians and bureaucrats but which is becoming agonizingly clear to the taxpaying, saving, producing middle class which makes up the majority of the electorate in this country.

Spending by the Department of Health, Education, and Welfare has contributed mightily to inflation according to Dr. Donald Quinlan, a private practitioner who presented beautifully documented testimony before the Health Subcommittee of this committee on September 12, 1975. HEW plans to spend over $118.4 billion in fiscal 1976. Medicare and medicaid, which cost six times more in 1974 than predicted, now in 1975 will cost nine times more than promised at the end of the first 10 years of the program. Dr. Quinlan pointed out that the HEW figure for 1976 of $118.4 billion is greater than all the profits after taxes of all the corporations in the United States and more than all the personal savings of all the people in the country. How close is this Nation to bankruptcy? How can this committee in good conscience report out any new health program for our people that would add billions more to the deficit and the national debt? Someone has mockingly but sagely pointed out that the only difference between the financial plight of New York City and the United States is that Uncle Sam can print ever-cheaper paper money. New York can't. Perhaps this idea crossed the mind of Senator Long the other day when he described his catastrophic health bill in the Senate as "the only feasible alternative to the potentially disruptive and bankrupting effect involved in proposals which would radically alter and almost scrap existing structures and mechanisms." Even his bill would add $9 billion more to topheavy HEW budget and that, if past predictions teach us anything, is likely a gross underestimate.

By strengthening and feeding the Federal executive bureaucracy over the past 40 years the Congress has created a monster which it can no longer easily manage and by which it is intimidated. The monster now directs and manipulates its creator and is fattened and progressively strengthened at its own demand. This is especially true of the Department of Health, Education, and Welfare and its powerful Secretary. This huge army of unelected bureaucrats seems to look on the people's representatives as its pawns, pieces to be played in a game of cumulative political power. It connives to make the Congress ever more subservient and malleable. Unless the Congress can gather its wits and cut off the money which feeds this monster, the ultimate form of government which rules our sons and daughters will be a national Socialist bureaucratic dictatorship, not easily distinguishable from the European tyrannies of the present and of the recent past, which totally guides and regulates our descendants' institutions, economy, education, health care, and their very lives. This is what I thought we all spent time in World War II to prevent.

DESTRUCTIVE ASPECTS OF PROPOSALS FOR NATIONAL HEALTH INSURANCE

After unraveling the intricacies of the official language of the various national health bills now before this committee, one finds they all have some things in common. They are astronomically expensive and they are inflationary. They are compulsory and they are dictatorial.

They greatly increase the powers of the Department of Health, Education, and Welfare and its Secretary, and will expand this bureaucracy to even greater elephantine size. They promote to varying degree Government monopoly over the Nation's health care. They are restrictive and they limit freedom of choice. They require the rationing of medical care under mechanisms already being set up for that purpose. They tend in one way or another to turn the Nation's doctors into Government agents either by persuasion or by decree. They will reduce the number of doctors in private practice and will drive more than 25 percent of the doctors in the country either out of medicine altogether or into some field of medicine outside of national health insurance. This is clearly documented in a huge survey of 26,000 doctors by the magazine Private Practice. Over the long haul the passage of a National Health Insurance Act slowly but inevitably will cause the quality of medical care to deteriorate, initially at the family practice level, but ultimately at every level, as demand outpaces supply and available funds become more and more limited just as has happened in Great Britain. The crushing expense and the shattering failure of the British experiment in government management and control of medical care is alarming and clear to the American public.

Eighty-five to ninety percent of the people in the United States are satisfied with their present medical and hospital care; more than 75 percent are insured against the usual costs of that care, and the percentage continues to grow. It is irrational and destructive to change and disrupt the entire system of medical care in this country to cover the unmet needs of the remaining population whose care even now is being constantly upgraded.

PRESENT PLANS AND MECHANISMS FOR RATIONING HEALTH CARE UNDER NATIONAL HEALTH INSURANCE

All federally subsidized health plans are now subject to the Professional Standards Review Organization (PSRO) amendment which is a dictatorial device that enables the Secretary of HEW to control medical and hospital costs by rationing medical care in the hospital and later in our doctors' offices. Peer review for the improvement of medical care is as old as the history of medicine and voluntary consultation was the rule before the days of Hippocrates.

But under compulsory PSRO, doctors have been persuaded to act as Government agents and to become part of the apparatus of socialized medicine by appealing to their natural desire to improve the quality of medical care. Having been frightened into believing that there are worse things than collaboration in their own ensnarement by the bureaucracy, doctors will police doctors in a vain attempt to control the rapidly increasing cost of Federal health programs.

Unfortunately, doctors can't control these costs because health care costs are tied chiefly to general inflation and partly to more expensive medical techniques and therapy and in addition to the health care inflation which occurs within the general inflation as the federally subsidized increase in demand for medical services and items outstrips the supply. The poor doctor will be the scapegoat again when he fails to control costs.

The constitutionality of the PSRO amendment, an intrusion by the Federal Government in the contract between a patient and his doctor and an invasion of each patient's privacy by the Federal bureaucracy, is being challenged in the Federal courts by the Association of American Physicians and Surgeons. Some of you on this committee are aware of these facts and in the past have called for repeal of the PSRO amendment. I am grateful to you.

While I am on the subject of the rationing of medical care which is planned for Government programs, I should like to draw your attention to the maximum allowable costs (MAC) program of the former Secretary of HEW, Mr. Caspar Weinberger. This is another example where bureaucratic regulation would appear to exceed the will of the Congress; where the HEW dog wags the Congress as its tail.

The Congress in the original Medicare Act has specifically forbidden the Secretary of HEW to interfere in the way medicine is practiced. Yet, in July 1975, shortly before his resignation, the MAC regulations were signed by Mr. Weinberger in spite of a torrent of opposition following their publication in the Federal Register. Opposition was expressed by 95 percent of the 2,200 who commented on MAC.

The regulations, when they are implemented, will permit payment by the Government under Federal health programs for the cheapest available drug in any generic class declared bioequivalent and bioavailable by the Food and Drug Administration. Thus, the poor and the old are limited to cheap drugs of possibly inferior quality since it is widely agreed that techniques for assessing equal absorption and equal activity of the same class of drugs made or packaged by the many drug firms, here and abroad, are not yet reliable.

This sort of rationing to reduce cost is risky, discriminatory, and unacceptable. The Secretary seeks to change the way drugs are prescribed and dispensed, and will attempt to interfere and tamper with the way medicine is practiced. If the Secretary of HEW can limit medication to the cheapest available, what is to prevent his rationing medical care to the cheapest available physician or to provide the cheapest available bed or equipment or technique under present programs or under a new all-encompassing national health insurance scheme? It is little wonder that the American Medical Association is seeking a permanent injunction against this mischievous new intrusion.

CRITIQUE OF H.R. 10028, CATASTROPHIC HEALTH INSURANCE AND MEDICAL ASSISTANCE REFORM ACT OF 1975

This bill, which it is said will cost "only" $9 billion initially, will, if enacted, among other things, attempt to provide catastrophic health insurance for every American—135 million of whom already have catastrophic health insurance—after 2 months of hospitalization and physician's bills of $2,000, levy a huge tax of 1 percent of all wages paid by every employer, some of which will be saved by a tax credit, supposedly encourage the growth of private catastrophic insurance coverage under Government regulation, transfer all medicaid welfare program to Federal management and pay for the health care of the "low income" individual and his family under this new Federal plan. It will, in addition, permit private insurers to submit, voluntarily, private medical and hospital insurance plans to the Secretary of HEW for his approval and certification. This bill identifies some weaknesses and important problems in the financing of health care but proposes faulty solutions.

The payment of the entire catastrophic health plan by the compulsory tax on employers is abhorrent to me. The tax will be passed on to consumers as increased costs for goods and services and therefore amounts to a hidden sales tax which will fall on poor and rich alike.

It would appear to me that any private insurance plan for catastrophic care should be able to stand on its own merits and that the Government's role, if any is needed, should be, through investigation and research, to encourage the insurance industry to provide adequate coverage. Certification of these policies should not be the responsibility of the Department of HEW. Compelling people to pay, in one way or another, for catastrophic health insurance and then giving the bureaucracy total control over this form of health coverage by allowing the Secretary of HEW, not only to compete with the industry, but to dictate the terms of the policies and the means of competition increases his power and virtually delivers into his hands the management of all catastrophic insurance, public and private. The people's choice is limited and the bureaucracy grows and is strengthened. I would not subject catastrophic health plans, privately financed, to manipulation by the Federal Government and the Secretary of HEW in any way.

The bill is inflationary. Besides increasing the cost of living by raising the cost of all goods and services through an employer's tax passed on to all consumers, there is an inherent perpetual inflationary aspect to the bill which permits increased benefits almost automatically as general inflation rages on. This cannot but require an increase in the tax on employers and a further increase in the cost of living. We see again Government's role in giving the inflationary spiral another spin upward.

Moving the medicaid program away from local control to complete Federal administration will save no money and I doubt if it will increase efficiency. I would oppose this part of this bill. Past experience has shown that the closer to Washington these welfare programs are drawn, the less precise and responsible the cost control and the greater the expense. If the individual States of the Union are already suffering deficits because of the uncontrolled costs of medicaid, where will the Federal Government find the people with money enough to pay these same taxes at the national level? Besides, does this not anticipate that medicaid costs will continue to multiply at an even faster rate when cost controls at the State level, irritating to free spending national bureaucrats, are no longer a roadblock to expansion? Medicare and the artificial kidney program have far outstripped all original estimates of cost, not only because there was more to be done than was admitted, but also, perhaps, because the planners, in order to sell their programs, invariably promised costs which are a fraction of the total heavy expense easily predictable by people outside of Government who have no vested interest in expansion. Welfare programs should be managed, and for that matter taxed, at the local and State level where they can be monitored by people who live in and know the community served and where the cost of administration can be held to a reasonable level.

Many physicians refuse or are reluctant to treat medicaid patients because regulations force them to take their fees for service by assignment and make them, to that extent, employees of the government. Inclusion of the low income group of citizens by this measure likewise may limit their easy access to medical care and their freedom of choice.

That portion of H.R. 10028 which attempts to standardize and improve the quality of all health insurance plans throughout the Nation has good intentions but one major danger. I think it hazardous, indeed, to delegate to the Secretary of HEW the right to evaluate and certify private health insurance plans. This surely lets the fox in the henhouse. Giving this additional power to the Secretary makes him a virtual czar over the entire health insurance industry. It is noteworthy that the bill gives the Secretary the aditional authority to establish Federal health insurance wherever, in his wisdom, he judges no satisfactory health insurance plan exists. The conflict of interest and the temptation here is all too obvious. An independent, nonpolitical commission should be set up by the insurance industry to evaluate and standardize health insurance policies for us all and to grant certification as desired by the insurance carriers. Every precaution possible should be taken to prevent the absorption of the private health insurance industry by the Federal Government. There is more than one way to nationalize private insurance companies and this bill seems to present a blueprint for the progressive takeover of private health insurance by the Federal bureaucracy. This cannot be allowed to happen.

In summary, an increasingly concerned American public, some of whom are my patients, are now fully aware that inflation is caused chiefly by the deficit spending of our fiscally irresponsible, ever-expanding, monstrous Federal Government. They see the true value of their incomes reduced and their savings plundered. They find themselves hampered and harassed by a plethora of bureaucratic controls, regulations, and redtape. They no longer trust their elected leaders, they fear the increasing power of the Federal bureaucracy and they want the Federal Government off their backs.

All plans for national health insurance call for enormous Federal spending, expansion of the size, the power and the controls of the Federal bureaucracy, heavier taxation and greater inflation. Federally financed medical and hospital care must necessarily be tightly regulated and firmly rationed. Mechanisms for this regulation and rationing are already established. No government on earth can possibly meet, without limitation, all of the increasing demands of its people for medical care. There is absolutely no weight of evidence at home, and certainly ample evidence to the contrary abroad, that this expansion of Federal power and this increase in Federal debt is justified.

The fact is that the spending of the billions of dollars involved in the plans for national health insurance must further weaken our free enterprise economic system and threaten the political stability of our Government, our free institutions, and our liberty.

Only you gentlemen here in the Congress of the United States can prevent this disaster. Thank you.

[Material appended to Dr. Ball's statement follows:]

Inflation: Its Cause and Cure

W. PHILIP GRAMM

W. Philip Gramm is a professor of economics at Texas A&M University in College Station, Texas. Professor Gramm has published articles in various economic journals on topics ranging from environment to monetary and banking theory. He is a consultant to the U.S. and Canadian Governments on matters of energy and economics. Professor Gramm presented this paper at the Federal Reserve Bank of St. Louis on February 7, 1975.

WE ARE today experiencing the most prolonged period of rapid inflation in the history of the United States. While we have had short periods where inflation rates have been more intense, a decade of high inflation rates is without precedent in the history of the Republic. As an index of how severe price increases have been for the last decade, the consumer price index, which measures the price of a market basket of goods and services purchased by the American consumer, is up 66 percent; the wholesale price index, which measures the price of raw materials used in the production process, is up 75 percent from a decade ago. Not only have we experienced a decade of high inflation rates, but in the last year the rate of price increase has quickened. The consumer price index is up 12 percent from a year ago and the wholesale price index is up 20 percent. These harsh economic facts suggest two questions: (1) how did we get in such a mess, and (2) how do we get out?

The first question is easy to answer. There are data on inflation which go back to the 15th century, when gold was discovered in America, transported to Spain, and permeated the European market. Since that time there has *never* been a prolonged general price inflation that was not preceded by and directly related to a growth in the money supply. In our economy, growth in the money supply occurs principally when the Government spends more than it taxes and prints money to make up part of the deficit.

The History of U.S. Inflation

We have incurred five major inflations in the history of the United States: the Revolutionary War inflation, the War of 1812 inflation, the Civil War inflation, the World War II inflation, and the Vietnam War inflation. All five of these inflations have had the same cause — a rapid increase in the money supply. Under the Articles of Confederation, the Continental Congress did not have the power to tax. It was therefore forced to issue paper currency to fight the Revolutionary War. The paper currency units were called Continental Dollars. You have all heard the saying "not worth a Continental," a statement derived from the fact that when Continental Dollars were redeemed at the end of the Revolutionary War, they were redeemed at 2 cents on the dollar in gold and silver. The paper currency depreciated very rapidly because of the tremendous quantity which was issued. In essence, the Continental Congress was entering the American market and competing against private citizens for goods and services with newly issued Continental currency, buying goods at a more rapid rate than the economy was producing them. Prices, therefore, were driven up.

In reviewing our first inflationary experience as a nation, it is important to note that at the end of the Revolutionary War the Congress established the First Bank of the United States, which systematically withdrew Continental Notes from circulation. Prices then leveled off and fell back toward their original level.

The next major inflation in American history followed the War of 1812, which was basically a carbon copy of the Revolutionary War inflation. The principal method of deriving Federal revenue was imposing import taxes or tariffs. But we were at war with our major trading partner, England, and tariffs had fallen off drastically. In order to fight the war we therefore issued large quantities of paper currency which produced a rise in the general price level. Again, however, to the credit of our forebearers, when the war was over the Congress established a Second Bank of the United States that redeemed paper currency at par. Prices leveled off and declined back toward their original level as the paper currency was withdrawn from circulation.

Note: An earlier version of this paper was presented at Hillsdale College, Hillsdale, Michigan, in connection with a seminar sponsored by the Center for Constructive Alternatives entitled "Energy or Exhaustion: The Planet as Provider." See *imprimis* (November 1974), pp. 1-6.

The next major inflation in American history occurred during the American Civil War. The Federal Government ran a $1 billion deficit, which was without precedence in history. It financed a large part of this deficit by issuing Greenback Notes. These Greenback Notes expanded the money supply by over 150 percent, and prices roughly doubled from 1860 to 1865. At the end of the war taxes were left at their war-time level and Government spending was cut back drastically. The Government surplus drew Greenbacks out of circulation and the Treasurer of the United States burned them. As the money supply declined prices fell off, and by 1879 we went back on the gold standard at exactly the same par value that existed in 1860 because prices had been driven back down to their previous level.

The next major inflation in American history occurred in World War II. The Federal Government ran a large deficit and the money stock more than doubled as the Federal Reserve monetized a part of the debt. As the Government entered the market armed with newly printed money, it drove up prices, increasing overall prices by over 60 percent during the Second World War. By the end of 1946, we were approaching a balanced budget, and by 1947 price increases had ceased. We established a period from 1947 to 1962 (except 1950) which proved to be one of the most prolonged periods of stable prices and stable economic growth in the Twentieth Century.

The Current Inflation

The next major inflation in American history occurred with the initiation of massive Government expenditures on the Vietnam War. *We are today in the fifth major inflation in American history — and its source is identical to the four inflations that preceded it. The current inflation differs only by the fact that it has been carried over into a peacetime period; this is the only peace-time inflation of any real significance in the entire history of our country. Our present inflation has been caused by the fact that since 1965 the Federal Government has run a $100 billion deficit and has financed 40 percent of that deficit by printing money.*

It is fundamentally important to note the difference in the impact on the economy caused by Federal financing through taxation and borrowing, as opposed to printing money. When the Government taxes and spends the receipts of those taxes, the ability of the private consumer to purchase goods and services is diminished by the amount of the tax. Therefore, the increase in total spending as a result of the increase in Government spending is quite small. If the Government goes onto the bond market and sells bonds, competing with private firms and private individuals for loanable funds, the competition simply drives up interest rates as Government diverts funds away from private investment projects. In this case, private spending falls by the amount that public spending increases. In the case of selling Government bonds to the Federal Reserve, which in turn gives the Treasury the capacity to write checks drawn on the Federal Reserve, there is no corresponding decrease in private spending. So the increase in Government spending represents a net increase in total demand for goods and services.

There is a simple rule of thumb to follow in gauging the relation between the growth in the money stock, the growth in the economy, and changes in prices. Remember what money is used for — it is used to buy and sell goods and services and consummate exchange. We have found in economics that as the level of economic activity grows with the growth in income and commerce, the demand for money grows by a corresponding amount. So if the economy grows at about 3 percent a year, which has been the average growth rate throughout the entire history of the United States, then the economy will absorb a 3 percent growth in the money supply with no change in prices. For example, from 1947 to 1962 the Federal Government ran small deficits and the money stock grew at about 3 percent per year as the Federal Reserve purchased Government securities in the open market to keep interest rates low. The economy grew at about 3 percent a year so that the increase in money supply was simply absorbed in the consummation of exchange, and prices remained virtually stable for the entire period. One exception was the year 1950, when the economic impact of the Korean conflict was felt; the money supply grew by 10 percent and prices increased 10 percent.

Beginning in 1964 we had large increases in Federal spending to finance unprecedented domestic expenditures on the War on Poverty and on Great Society programs. With the escalation of the war in Vietnam we saw the Government deficit rise from a fairly low level in 1964 to $25 billion a year in 1968. The so-called anti-inflationary surcharge imposed in 1968 had no real impact on inflation rates because Government expenditures grew more rapidly than tax receipts. As a result, in 1968 we ran a record peacetime deficit and the money supply grew by almost 8 percent.

In 1969, when President Nixon took office, we made the only real attempt in the whole inflationary period to stop the inflation. Beginning in January, President Nixon brought the budget into balance, and the rate of growth in the money stock from January to June was zero percent. This policy worked because the rate of price increase, which was almost 6 percent on an annual basis in December and January, had fallen to a 2.7 percent rate by June. But in April, May, and June the unemployment rate jumped significantly.

Unemployment rose principally because in the wage negotiations which occurred in the fall of 1968, wage contracts were based on the assumption of a continuation of 5-7 percent inflation rates. This expectation was realistic, given our previous five-year experience. So an employer who expected the productivity of his workers to rise by 2 percent was willing to negotiate a 7-9 percent wage increase if he expected the price of his product to rise by 5-7 percent. Workers, being aware of the same set of circumstances, were unwilling to accept any smaller pay increase. If the Federal Government had continued its expansionary monetary and fiscal policy, such wage negotiations would have caused no changes in the unemployment rate. But when the Federal Government reversed its monetary policy in an attempt to stabilize prices, and the rate of price increase fell below 3 percent by June, the wages that had been negotiated in the fall of 1968 were too high for full employment and workers were laid off.

The Federal Government at this point faced a crucial decision between two options. (1) It could reverse its monetary policy, reinflate, and therefore seek to drive up prices, which would produce a fall in real wages to the point necessary to produce full employment; or (2) it could maintain its monetary policy, and allow the new contracts written in the fall of 1969 to be based on a 2.7 percent inflation rate and a higher unemployment rate.

In 1969 and 1970 the Government reversed its policy and began to inflate at an increasing rate in the last six months of 1969 and 1970. By January of 1971 the inflation rate was back up to a 6 percent annual rate and the unemployment rate was beginning to slide. Since June of 1969, when we abandoned our only real attempt to stop the inflation, we have made no significant attempt to bring inflation under control in this country. We have sought to find easier solutions to our economic dilemma. At first, in the second half of 1969, we tried a voluntary approach. Then in 1971 we went to the mandatory approach when we imposed wage and price controls and attempted to freeze prices and wages in the United States by Government edict.

While we in economics have a lot of data on inflation, we have even more data on wage and price controls. In fact, our first history of wage and price controls occurred 5,000 years ago when price controls were imposed in the fifth dynasty of ancient Egypt. Pericles imposed price controls in ancient Athens, and Diocletian imposed wage and price controls in ancient Rome. *And from the fifth dynasty of ancient Egypt to President Nixon's Phase IV price controls, all of these experiences have one thing in common — not one has ever worked. And they do not work for a very simple reason: they freeze prices at a level where the quantity demanded exceeds the quantity supplied. They simply turn price increases into shortages and stifle the incentive to produce, therefore causing output to fall.*

We have in fact produced a minor miracle in the United States in the 1970s, in that at various times we have produced a grain and a meat shortage through Government policy — in a country that has the most fertile land, the highest level of capital equipment and technology in agriculture, and the best educated farmer in the world. We have produced shortages of critical inputs to the production process, sending the country into a recession.

If one looks at what the Government says it is doing in its "anti-inflation" policy, and then looks at the growth in the monetary base to see what it is actually doing, there is only one conclusion that can be drawn. That conclusion is that Federal anti-inflation policy since June of 1969 has been a "fraud." *Over the last 12 months the monetary base has grown at almost an 8 percent annual rate. Never in history has such a rate of monetary expansion failed to produce rapid inflation.*

Pointing the Finger of Guilt

When the Federal Government, in June 1969, stopped trying to do anything about inflation it turned its activities toward developing scapegoats in order to get Americans to blame their neighbor for their problems. Had the scapegoat strategy not been so effective, it would be humorous. How does this strategy work? Well, you have all heard it. It works basically as follows. A bureaucrat goes to a businessman and says, "Why are you increasing your prices?" And the businessman says, "Because our costs are rising." And then the bureaucrat says, "What is your major cost?" And the businessman says, "labor." And then the bureaucrat concludes, "Well, labor unions cause inflation." And then the same bureaucrat goes to union leaders and says, "Why are you demanding such high wage increases?" And union leaders note that the consumer price index is up 12 percent in the past year, and that wages of hourly workers are 4 percent lower than they were a year ago in terms of real purchasing power dollars. And the bureaucrat says, "Well, who sets prices anyway?" And the labor leaders say, "businessmen." And the bureaucrat concludes, "Well, through price collusion and administered prices, businessmen create inflation."

Then, of course, another popular version of scapegoatism was employed by former Treasury Secretary John Connally. He said, "We are all causing inflation through our greed. We are all so greedy in competing against each other for goods and services that we are, through this competition, driving up prices. We have all just got to stand back and quit being so greedy." I guess the low point in scapegoatism was reached when Herbert Stein pronounced, just before his retirement from the Council of Economic Advisers, that the American people were responsible for inflation.

Picking up the scapegoat theme, Jack Anderson wrote an article in which he said high interest rates are the result of banker collusion in an attempt to drive up the interest rate to make fat profits at the public's expense. This statement, I think, showed that Jack Anderson knows nothing about banking and finance and nothing about economic history, because never in the history of the United States have we had high inflation rates which have failed to produce high interest rates, except during periods of capital rationing.

Our high interest rates over the last year, which have disrupted the long-term capital market, have been caused by irresponsible Government policy. I think it is important that we not allow bankers and businessmen to be used as scapegoats for Government failure. In fact, if one looks at nominal interest rates and the current inflation rates and attempts to draw any parallel between current interest rates, in terms of real resources borrowed, relative to real resources paid back, interest rates last year were not at historic highs, as we were told in the newspaper and on the news. They were at historic lows. We hear from Washington that Government economists marvel at record demand in the short-term credit market in the face of record high interest rates, but if one can borrow at 12.5 percent on prime commercial paper and the inflation rate is 12 percent, he is paying back in real terms only 0.5 percent interest. *It is indeed no marvel that the demand for capital in the short-term credit market has been at a record high, because real interest rates have been at a record low.* Indeed, if the Federal Reserve had not been following an easy money policy through open market purchases of Government securities, interest rates on short-term credit would probably have reached 15 percent last year.

The Costs of Inflation

While high nominal interest rates have not disrupted the short-term credit market, they have had a disastrous effect on the long-term credit market, and the reason is very simple to understand. Historically, we in the United States have been blessed with fiscally responsible Government. Indeed, if you throw out all the war years in American history, prices on the average have remained constant or fallen slightly throughout the entire history of the United States. As a result, we have had historically low nominal interest rates. Therefore, borrowers are loathe to commit themselves over 25 - 30 years to a nominal interest rate that, although it may be 2 percent or negative (in real terms) at current inflation rates, might later turn out to be an extremely disadvantageous rate if the current inflation should end. Secondly, at high inflation rates, funds have been diverted from their traditional channels, whereby savings flowed into commercial banks and savings and loans institutions, and were in turn loaned out to businesses to build new factories, to generate jobs, and to build new homes. As a result of high inflation rates and interest ceilings on banks and savings and loan associations, funds have been diverted into land and commodity speculation and large Government bond issues.

We are all aware of the impact of inflation on income redistribution, particularly on those with fixed salaries, the old, and the poor. There is no question that this is a major cost of inflation. But an additional, more important cost is the impact caused by diverting funds from traditional channels and disrupting the link between the saver and the investor. In this way, we are today planting seeds which will yield lower economic growth rates for a decade.

Today we have a 7.1 percent unemployment rate which is highly concentrated in two industries — the construction industry and the automobile industry. As the effects of the recession in these industries spread, the unemployment rate will rise further. High interest rates, uncertainty about future prices, and the availability of gasoline go a long way in explaining the plight of these industries. While the $52 billion deficit in fiscal 1975 will stimulate these industries, most of the stimulation will occur in nondepressed industries. A deficit of such magnitude will assure that interest rates will be bid up as Government competes with private industry for loanable funds. If the Federal Reserve monetizes 40 percent of this deficit, as it has done over the last decade, the money supply will expand by over 20 percent and double-digit inflation will occur in 1976, even if we experience the most rapid economic recovery in American history.

Government: The Cause of Inflation

How do we stop the inflation? Inflation has one cause and it has but one cure. And that one cure is to slow the rate of growth in the money supply. This can be accomplished only by closing the Government deficit. Our inflation has resulted from the prevalence of a bankrupt (and bankrupting) idea within Government that money solves problems. If one looks at the historic growth pattern of Government spending over the history of the United States, it is very easy to discern that within the last 15 years there has been a fundamental change within our Government. From the birth of the United States it took over 180 years for the Federal budget to grow from roughly zero to $100 billion. It took only ten years to grow from $100 billion to $200 billion, and it has taken only four years for it to grow from $200 billion to $300 billion. Despite the fact that Federal tax collections have grown by 110 percent over a decade, over three times the rate of economic growth, the Federal Government has failed to live within its budget. According to Treasury Secretary William Simon, *the Federal Government is deficit financing at such a rate that today it is absorbing 60 percent of all the funds raised in U.S. capital markets.*

In January I had the pleasure of working in Washington for my Congressman, Olin Teague, on the Energy Emergency Act. While I was there, Congressman Teague asked me if I would read some of the bills that he had to vote on during the period I was working for him. I noticed that despite the fact that I make my living reading and writing, I was unable to read the bills as fast as they came in, so the stack on my desk kept getting higher and higher. Finally, I realized that it was physically impossible for any Congressman to read the bills he had to vote on. I assert here today that no member of the United States Congress read the $25 billion education act that has just become law. The sheer bulk of paperwork is so great that no effective research is being done in the Congress by those who are actually engaged in the process of making decisions in the public interest. We are experiencing an attempt by the Congress to substitute money for ideas.

Probably the best statement of the money-solves-problems philosophy that I have ever heard was John Lindsay's statement shortly after he became mayor of New York. The gist of John Lindsay's message was as follows: people think New York City has a lot of problems, but New York City has only one problem — private affluence and public poverty. If my budget were simply twice what it is today I could solve every problem in New York City. The day John Lindsay left office his budget was over 2 times what it was the day he took office, and by every index from garbage collection to crime in the streets, New York City was a worse place to live the day he left than the day he came. And the reason is that money does not solve problems, ideas solve problems. And Government has had few viable ideas in 40 years.

The best personal example that I have witnessed of the bankruptcy of Government with regard to new and viable ideas was a call I received back in January. I was working in my office at Texas A & M and my secretary, who gets excited with very little provocation, came into my office and said, "Dr. Gramm, you're not going to believe this, but the President of the United States is on the telephone." And I said, "You're right, I don't believe it." Nevertheless, I picked up the phone and a very stern sounding lady said, "Is this Dr. W. Philip Gramm of Texas A & M University?" I said, "Yes, Ma'm." She said, "Dr. Gramm, this is the White House calling."

So I sat on the edge of my chair awaiting some message — some mission from my President — and a member of the White House staff came on the phone. He said, "Dr. Gramm, your name has been given to us by some very, very important people. We think you might be the kind of person that can help us develop a new and viable energy program, a system of Government controls and subsidies, a system of Government and industry mutual research and project participation. And as an index of our commitment to this project we are willing to commit $20 billion."

He went on and used every 25-cent word in the English language. When he got through, being an Aggie, I said simply, "It is a happy coincidence that out of 211 million Americans you have called the right man, because I know exactly what to do." I told him that I envisioned a system which was not going to cost a penny, but in fact would make money. It would be so productive that we could tax its output and finance Government programs on the basis of its productivity. I told him that I envisioned a system whereby we would allow people to own property, and we would allow them to combine this property with their God-given talents to produce output. We would allow them to sell output in a free market so that each individual, in attempting to maximize his own welfare, would operate at maximum efficiency. And each consumer, in attempting to maximize his own individual welfare, would economize on the things that were scarce and therefore expensive, and substitute for them things that were abundant and therefore cheap. In such a system, by rewarding production and innovation, we could assure a maximum level of economic growth. I told him that I was basically a modest person and that I wanted him to know this was not totally my idea; that in fact if he would like a written reference, he might look at Adam Smith's *Wealth of Nations*, written in 1776. And I hung up.

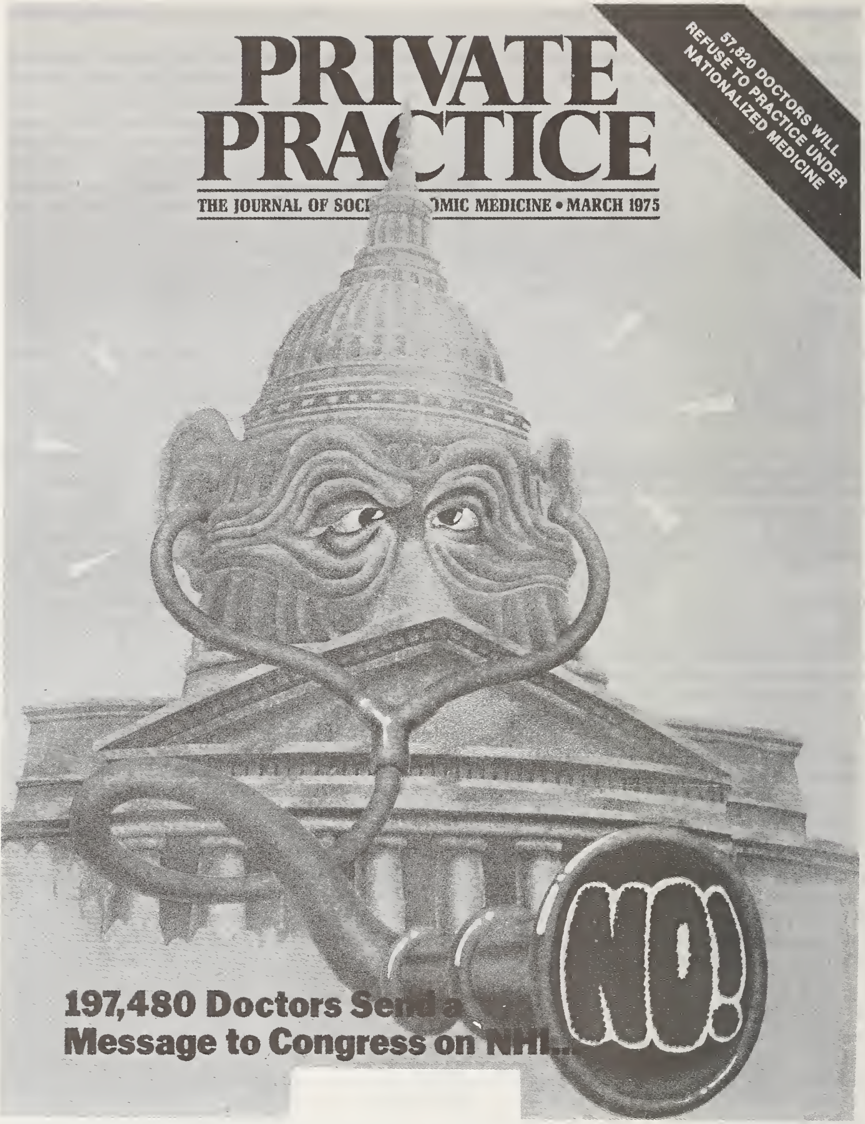
Well, I assumed that I would never hear from the White House again, but indeed they went to a great deal of trouble to get in touch with me. And that's how, as I expressed it, for about a two-month period, while I didn't invent free enterprise, I had the sole Washington distributorship on it.

Conclusion

If we are to ever put an end to spiralling prices, shortages, high interest rates and, economic stagnation, we must stop the growth of Government and put our monetary and fiscal house in order. To reverse the trend of fiscal irresponsibility we need strong leadership, which is a scarce commodity in Washington today. We must resist the siren song of more and more Government spending and more and more Government controls, and stand up for the free enterprise system which has made us prosperous and free.

The hour is late. It has become quite fashionable to proclaim the inevitability of the demise of our system. Such a philosophy is a convenient escape. For if there is not hope, we are not obligated to do anything. In fact, there is no real reason for pessimism. We have human talents on our side. We have money and economic power on our side, and most important, we have history on our side. We have, in the American free enterprise system, the most successful economic system in the world. It has elevated us from a powerless nation, 90 percent of whose citizens were in poverty — by any measure — at the time of the Revolution, into the greatest agricultural and industrial power on earth. So successful is our system and so high are the aspirations of the American people that we define poverty at an income level that is higher than the average income level of the world's second most powerful nation. Yet, paradoxically, this great system is under attack at all levels of Government, and is being replaced by a system which has never worked in history and which is working effectively no where in the world today. The greatest product in history is not selling for the simple reason that it has no salesman. Those within our Government who supposedly represent our views are defending our system with an ineptitude unparalled in the history of the Republic. To reverse this trend we need but a unit of will.

I wish to tell you today that I am optimistic about the future of America, and I am optimistic about the future of the American free enterprise system. If we have learned anything in the 1970s, it is that big Government cannot solve problems, and that spending more of the taxpayers' money cannot turn a bad idea into a good one. Everywhere I go in Texas and in our nation I find the American people feel a sense of helplessness. They know big Government is not working, they know something is out of kilter, but they don't know what to do about it. What we need today, more than at any time in the history of the United States, is a new wave of leadership to turn this country around. We need this leadership to fulfill the ideals and aspirations of a revolution which occurred almost two hundred years ago. In the coming struggle for the survival and the success of the American experiment, I call upon you as our business and civic leaders not to be merely passive observers, but to be active participants. While I cannot speak for the actions of others, in my own case I mean not only to participate, I mean in that participation to lead.


PRIVATE PRACTICE
THE JOURNAL OF SOC OMIC MEDICINE • MARCH 1975
57,820 DOCTORS WILL REFUSE TO PRACTICE UNDER NATIONALIZED MEDICINE
197,480 Doctors Send a
Message to Congress on NHI...
NO!

197,480 Doctors Send a Message to Congress on NHI: NO!

by Francis A. Davis, MD

In the Autumn of 1974, a survey of 2,713 New York City-area physicians by the Columbia University School of Public Health claimed that 56 percent of doctors support National Health Insurance. This support ranged from a low of 40% among general practitioners to a high of 80% among psychiatrists. The study's sponsors called the 56% figure "surprising . . . in view of the commonly held view that the medical profession is opposed to NHI."

We found the results, which garnered national publicity, doubly surprising, since, in our experience, the doctors who take care of the vast majority of the sick people of our country — private practice physicians — are overwhelmingly opposed to National Health Insurance.

To discover just where the truth lay, we attached a questionnaire to the January 1975 issue of **Private Practice**, asking doctors to tell us how they felt about nationalized medicine. The results proved to us that physicians are worried about NHI, since 28,014 busy doctors took the time to fill-out and return their questionnaires. To get the results into our March issue, we tabulated the first 26,434 — far more doctors than have ever participated in a survey on this subject which is so important to the future of America and the continuance of quality medical care. Because of the age, specialty, state, and sex distribution of the doctors who responded to our survey, we believe these 26,434 to be an accurate sampling of the nation's 212,573 physicians. Our figure is even more impressive when you realize that the famous national opinion polls extrapolate from a base of some 1,500 persons. Using the percentages obtained from the 26,434, we have extrapolated from our sample to obtain the total figures.

Although there was some difference by age, specialty, geographical region, and sex, we found great unanimity among physicians on these questions, despite what the Columbia and similar surveys have reported.

For example, on question one: "Do you believe the Federal government should pay the medical bills for all your private patients whose care is not now defrayed by some governmental agency?", the overall results were 7.1% Yes; 92.9% No. That is, 197,480 doctors oppose NHI. The highest percentage of No votes — 95% — was among physicians over 70, but doctors under 30 also said No by 83.2% to 16.8%. All other age groups were over 90% No.

Male doctors voted 93.0% No; the corresponding figure for female physicians is 89.0%. A difference, but again, hardly a significant one.

Doctors in all areas of the country strongly oppose NHI, from a high of 96.7% in the East South Central states to a low (?) of 84.3% in New England.

As in the Columbia survey, we found general and family practitioners most adamantly against a Federal take-over of medical care — 94.0% and 94.5% respectively, with psychiatrists most in favor. But even in the latter case, 85.6% of psychiatrists oppose NHI.

Many doctors have a parent who is also a doctor. Would this tradition continue under National Health Insurance? Question two asked, "If you had a son or daughter considering the study of medicine, would you advise him or her to become a doctor and practice under a nationalized medical system?" Overwhelmingly, doctors said No: 80.5%.

There was more variation in these figures, however. 68.5% of physicians under 30 would not advise a child to enter medicine. 65.2% of psychiatrists agree. The figures climb, to a high of 87.5%, as age increases, and the two highest for types of physicians are 86.0% for GPs, and 88.3% for osteopathic physicians. The regional variation is somewhat less: 71.3% for New England; 84.6% for the East South Central States. 80.7% of male doctors say No; 75.5% of women physicians also say No.

Although National Health Insurance has proven disastrous to the health and national budget of every country where it's been tried, our survey shows that the results in the United States could be infinitely worse.

Whenever an economic good is offered by the government at a price lower than the free market would set, demand skyrockets, making the good scarcer and the price higher. We have seen it work with Medicare and Medicaid, but NHI will be significantly worse.

Under present conditions, there are 212,573 private, office-based physicians to treat patients. Some say there is a doctor shortage. But if NHI is enacted, the number of doctors treating patients will drop precipitously, putting a dangerous burden on the remaining physicians. Medical care will be much harder to get, and much more expensive, even though most of the additional costs will be financed through taxation rather than out-of-pocket fees.

Proof for this apocalyptic statement? Question three of the PRIVATE PRACTICE NHI survey asked, as far as we know for the first time, "If Congress enacts a nationalized medical program, will you continue to practice under such a program?" 72.8% said Yes, but an astounding 27.2% said No. In other words, if National Health Insurance is indeed an idea whose time has come, as Richard Nixon said, then *57,820* doctors will refuse to participate. Imagine what will happen to American medical care — hitherto the best in the world — if we lose over 27% of our doctors. These will be the doctors we can least afford to lose — the primary care physicians of which, says Congress, we already have too few. What will they do? The answers to Questions 4B, 5B, 6B, and 7B (answered by the doctors who said No to Question three) tell us.

20,237 doctors of all ages will retire. The 37,583 who will not retire will either continue to care for non-NHI patients, give up medicine and seek some other kind of work, or go into full-time medical work not requiring them to be responsible for patients.

Of the doctors who answered Yes to Question three, 77.5% believe that in comparison to private medical care, patient care under nationalized medicine will be poorer. 3.5% say better; 19% say about the same.

75% believe NHI medicine will be more expensive than private practice; 4% say less expensive; 21% about the same.

Most unexpected, of the doctors who say they will practice under NHI, 63.2% — which would mean 97,804 physicians — would retire if they were financially able, rather than participate in a National Health Insurance scheme.

These are figures the Members of Congress must listen to. Not only will National Health Insurance come close to bankrupting a nation already reeling from government-caused inflation and recession, by adding over $100 billion to the national budget initially, with more to come, but it will disastrously deplete the ranks of private practice physicians. The morale of the doctors who continue to practice will be dangerously low.

What does all this mean? If the Congress passes National Health Insurance, quality medical care at a reasonable price will disappear for most Americans. Medicine in the United States will be dealt a blow from which it may never recover.

Private Practice survey shows:

197,480 doctors oppose National Health Insurance;

171,121 doctors would not advise their son or daughter to become a physician and practice under NHI;

57,820 doctors will refuse to practice under nationalized medicine —

- **20,237 doctors of all ages will retire rather than practice under NHI;**
- **37,583 doctors will continue to care for non-NHI patients, give up medicine and seek some other kind of work, or enter full-time medical work not involving responsibility for patient care;**

97,804 doctors who will continue to practice under NHI would retire rather than do so if they were financially able.

QUESTION 1

Do you believe the Federal government should pay the medical bills for all your private patients whose care is not now defrayed by some governmental agency?

	Yes	%	No	%	No Response
	1850	7.1	24066	92.9	518
By Category	**Yes**	**%**	**No**	**%**	**No Response**
Under 30	197	16.8	978	83.2	25
31 to 40	448	8.7	4678	91.3	92
41 to 50	371	5.5	6314	94.5	106
51 to 60	342	5.7	5705	94.3	99
61 to 70	259	7.0	3430	93.0	80
Over 70	44	5.0	843	95.0	22
Male	1598	7.0	21448	93.0	420
Female	93	11.0	778	89.0	22
New England	181	15.7	969	84.3	25
Mid Atlantic	444	10.4	3825	89.6	85
E. N. Central	291	6.0	4499	94.0	94
W. N. Central	77	4.0	1807	96.0	30
S. Atlantic	179	5.3	3222	94.7	71
E. S. Central	42	3.3	1215	96.7	20
W. S. Central	101	3.6	2731	96.4	39
Mountain	65	5.3	1163	94.7	26
Pacific	368	9.4	3546	90.6	90
GP	327	6.0	5143	94.0	108
FP	207	5.5	3533	94.5	65
IM	344	9.8	3148	90.2	67
OB GYN	133	4.9	2602	95.1	63
Urology	62	6.4	901	93.6	10
Allergy	22	6.0	340	94.0	10
Derm	42	5.2	769	94.8	13
Psychiatry	260	14.4	1544	85.6	39
DO	78	5.4	1371	94.6	31
Other	362	7.3	4609	92.7	95
No Age	189	8.2	2118	91.8	94
No Sex	159	8.0	1840	92.0	76
No State	102	8.6	1089	91.4	38
No Specialty	13	11.0	106	89.0	17

QUESTION 2

If you had a son or daughter considering the study of medicine, would you advise him or her to become a doctor and practice under a nationalized medical system?

	Yes	%	No	%	No Response
	4874	19.5	20071	80.5	1,489
By Category	**Yes**	**%**	**No**	**%**	**No Response**
Under 30	347	31.5	756	68.5	97
31 to 40	1078	21.9	3849	78.1	291
41 to 50	1321	20.7	5065	79.3	405
51 to 60	1013	17.4	4811	82.6	322
61 to 70	551	15.4	3022	84.6	196
Over 70	105	12.5	736	87.5	68
Male	4263	19.3	17868	80.7	1335
Female	203	24.5	624	75.5	66
New England	322	28.7	798	71.3	55
Mid Atlantic	946	23.0	3179	77.0	229
E. N. Central	818	17.7	3792	82.3	274
W. N. Central	318	17.7	1482	82.3	114
S. Atlantic	558	17.0	2727	83.0	187
E. S. Central	185	15.4	1016	84.6	76
W. S. Central	326	12.0	2391	88.0	154
Mountain	232	19.8	941	80.2	81
Pacific	913	24.3	2849	75.7	242
GP	740	14.0	4556	86.0	282
FP	626	17.5	2960	82.5	219
IM	816	24.6	2205	75.4	238
OB GYN	447	17.0	2187	83.0	164
Urology	167	18.2	752	81.8	54
Allergy	64	18.7	279	81.3	29
Derm	160	20.9	606	79.1	58
Psychiatry	602	34.8	1126	65.2	115
DO	167	11.7	1262	88.3	51
Other	1061	22.1	3737	77.9	268
No Age	459	20.0	1832	80.0	110
No Sex	408	20.5	1579	79.5	88
No State	256	22.2	896	77.8	77
No Specialty	24	19.2	101	80.8	11

STATES COMPOSING THE GEOGRAPHICAL AREAS LISTED IN THE SURVEY

New England
Connecticut
Maine
Massachusetts
New Hampshire
Rhode Island
Vermont

East South Central
Alabama
Kentucky
Mississippi
Tennessee

West South Central
Arkansas
Louisiana
Oklahoma
Texas

Middle Atlantic
New Jersey
New York
Pennsylvania

East North Central
Illinois
Indiana
Michigan
Ohio
Wisconsin

West North Central
Iowa
Kansas
Minnesota
Missouri
Nebraska
North Dakota
South Dakota

South Atlantic
Delaware
Dist. of Columbia
Florida
Georgia
Maryland
North Carolina
South Carolina
Virginia
West Virginia

Mountain
Arizona
Colorado
Idaho
Montana
Nevada
Utah
Wyoming

Pacific
Alaska
California
Hawaii
Oregon
Washington

ALL DOCTORS ANSWERING YES TO QUESTION 3 THEN ANSWERED QUESTIONS 4A, 5A AND 6A (THE CHARTS ON THIS PAGE). THOSE WHO ANSWERED NO TO QUESTION 3 ANSWERED QUESTIONS 5B, 6B AND 7B (THE CHARTS ON THE NEXT PAGE).

QUESTION 3

If Congress enacts a nationalized medical program, will you continue to practice under such a program?

	Yes	%	No	%	No Response
	19122	72.8	7125	27.2	187

By Category:	Yes	%	No	%	No Response
Under 30	1036	86.9	156	13.1	8
31 to 40	4314	83.1	875	16.9	29
41 to 50	5277	78.2	1465	21.8	49
51 to 60	4340	71.1	1768	28.9	38
61 to 70	2072	55.4	1668	44.6	29
Over 70	408	45.4	490	54.6	11
Male	17052	73.2	6258	26.8	156
Female	620	70.2	263	29.8	10
New England	915	78.9	245	21.1	15
Mid Atlantic	3085	71.4	1233	28.6	36
E.N. Central	3379	69.6	1476	30.4	29
W.N. Central	1386	72.9	516	27.1	12
S. Atlantic	2586	75.0	863	25.0	23
E.S. Central	918	72.4	350	27.6	9
W.S. Central	1990	69.6	869	30.4	12
Mountain	921	73.8	327	26.2	6
Pacific	3073	77.3	902	22.7	29
GP	3410	61.6	2125	38.4	43
FP	2727	72.3	1045	27.7	33
IM	2748	77.7	790	22.3	21
OB GYN	2064	74.2	716	25.8	18
Urology	790	81.7	177	18.3	6
Allergy	271	73.0	100	27.0	1
Derm	620	76.0	196	24.0	8
Psychiatry	1471	80.3	361	19.7	11
DO	1035	70.3	438	29.7	7
Other	3898	77.4	1139	22.6	29
No Age	1675	70.4	703	29.6	23
No Sex	1450	70.6	604	29.4	21
No State	869	71.6	344	28.4	16
No Specialty	88	69.8	38	30.2	10

QUESTION 4A

In comparison to private medical care, do you expect patient care under nationalized medicine will be:

	Better	%	About The Same	%	Poorer	%	No Response
	665	3.5	3568	18.8	14782	77.7	294

By Category:	Better	%	About The Same	%	Poorer	%	No Response
Under 30	90	8.7	279	27.1	661	64.2	14
31 to 40	172	4.0	843	19.6	3279	76.4	49
41 to 50	126	2.4	902	17.2	4223	80.4	75
51 to 60	120	2.8	754	17.5	3442	79.7	62
61 to 70	77	3.7	403	19.7	1570	76.6	51
Over 70	16	4.0	89	21.9	301	74.1	13
Male	567	3.3	3154	18.6	13234	78.1	253
Female	42	6.8	154	25.1	419	68.1	15
New England	64	7.1	248	27.3	596	65.6	22
Mid Atlantic	163	5.3	626	20.4	2280	74.3	52
E.N. Central	98	2.9	619	18.4	2646	78.7	45
W.N. Central	31	2.2	247	17.9	1106	79.9	14
S. Atlantic	77	3.0	446	17.3	2049	79.7	37
E.S. Central	13	1.4	140	15.3	762	83.3	12
W.S. Central	40	2.0	288	14.5	1653	83.5	21
Mountain	26	2.8	192	21.0	698	76.2	11
Pacific	117	3.8	618	20.3	2309	75.9	58
GP	110	3.2	551	16.3	2728	80.5	64
FP	86	3.2	491	18.1	2137	78.7	46
IM	132	4.8	620	22.7	1980	72.5	37
OB GYN	34	1.7	337	16.4	1679	81.9	32
Urology	18	2.3	128	16.3	641	81.4	9
Allergy	5	1.8	52	19.2	214	79.0	1
Derm	13	2.1	108	17.5	496	80.4	11
Psychiatry	97	6.7	361	24.8	998	68.5	26
DO	21	2.0	164	15.9	846	82.1	11
Other	145	3.7	732	18.9	3004	77.4	46
No Age	64	3.8	298	17.9	1306	78.3	30
No Sex	56	3.9	260	18.0	1129	78.1	26
No State	36	4.2	144	16.7	683	79.1	22
No Specialty	4	4.6	24	27.6	59	67.8	11

QUESTION 5A

Government medicine has so far been less effective than promised and much more expensive than projected, both to the taxpayer and the patient. Do you expect a completely nationalized system to do:

	Better	%	About The Same	%	Poorer	%	No Response
	766	4.0	4000	21.1	14214	74.9	329

By Category:	Better	%	About The Same	%	Poorer	%	No Response
Under 30	104	10.1	293	28.5	632	61.4	15
31 to 40	181	4.2	994	23.2	3109	72.6	59
41 to 50	158	3.0	1089	20.7	4003	76.3	76
51 to 60	125	2.9	788	18.3	3390	78.8	75
61 to 70	92	4.5	414	20.2	1545	75.3	50
Over 70	20	5.0	88	21.8	295	73.2	16
Male	637	3.8	3556	21.0	12736	75.2	279
Female	52	8.5	158	25.8	403	65.7	17
New England	77	8.5	236	26.2	588	65.3	29
Mid Atlantic	191	6.2	684	22.4	2185	71.4	61
E. N. Central	105	3.1	673	20.1	2576	76.8	54
W. N. Central	34	2.5	267	19.4	1077	78.1	20
S. Atlantic	84	3.3	511	19.9	1966	76.8	48
E. S. Central	8	.8	159	17.4	747	81.8	13
W. S. Central	34	1.7	330	16.7	1618	81.6	20
Mountain	30	3.3	195	21.3	688	75.4	14
Pacific	154	5.0	759	24.9	2140	70.1	49
GP	130	3.8	641	18.9	2616	77.3	66
FP	93	3.4	510	18.8	2114	77.8	43
IM	139	5.1	650	23.9	1930	71.0	50
OB GYN	38	1.8	420	20.5	1595	77.7	29
Urology	27	3.5	134	17.0	625	79.5	10
Allergy	4	1.5	52	19.3	214	79.2	2
Derm	14	2.3	135	22.0	465	75.7	14
Psychiatry	130	8.9	384	26.4	941	64.7	27
DO	30	2.9	202	19.6	798	77.5	12
Other	155	4.0	850	22.0	2858	74.0	64
No Age	86	5.2	334	20.1	1240	74.7	38
No Sex	77	5.4	286	19.9	1075	74.7	33
No State	49	5.7	186	21.5	629	72.8	21
No Specialty	6	7.0	22	25.6	58	67.4	12

QUESTION 6A

If you were financially able, would you retire from the practice of medicine rather than participate in a nationalized medical system?

	Yes	%	No	%	No Response
	11795	63.2	6876	36.8	638

By Category:	Yes	%	No	%	No Response
Under 30	410	41.0	588	59.0	46
31 to 40	2491	59.1	1721	40.9	131
41 to 50	3469	67.1	1703	32.9	154
51 to 60	2971	69.8	1285	30.2	122
61 to 70	1252	62.4	755	37.6	94
Over 70	208	53.6	180	46.4	31
Male	10634	63.8	6021	36.2	553
Female	304	50.8	294	49.2	32
New England	466	51.9	432	48.1	32
Mid Atlantic	1724	57.0	1302	43.0	95
E. N. Central	2120	64.3	1178	35.7	110
W. N. Central	873	64.2	487	35.8	38
S. Atlantic	1684	67.0	831	33.0	94
E. S. Central	614	69.1	274	30.9	39
W. S. Central	1422	72.7	534	27.3	46
Mountain	580	64.1	325	35.9	22
Pacific	1804	60.5	1177	39.5	121
GP	2324	69.9	999	30.1	130
FP	1787	67.1	875	32.9	98
IM	1489	55.7	1182	44.3	98
OB GYN	1377	68.2	641	31.8	64
Urology	537	68.9	242	31.1	17
Allergy	166	63.4	96	36.6	10
Derm	388	63.1	227	36.9	13
Psychiatry	670	46.4	773	53.6	39
DO	706	69.2	314	30.8	22
Other	2298	60.6	1497	39.4	132
No Age	994	60.7	644	39.3	60
No Sex	857	60.4	561	39.6	53
No State	508	60.2	336	39.8	41
No Specialty	53	63.9	30	36.1	15

DOCTORS ANSWERING QUESTIONS 4B, 5B, 6B AND 7B (ON THIS PAGE) ARE THOSE WHO ANSWERED NO TO QUESTION 3 ON THE PREVIOUS PAGE.

QUESTION 4B

Will you retire?

	Yes	%	No	%	No Response
	2279	35.0	4228	65.0	618
By Category:	**Yes**	**%**	**No**	**%**	**No Response**
Under 30	11	8.1	124	91.9	21
31 to 40	57	7.2	740	92.8	78
41 to 50	178	13.3	1162	86.7	125
51 to 60	500	31.5	1089	68.5	179
61 to 70	959	61.9	591	38.1	118
Over 70	321	69.8	139	30.2	30
Male	1957	34.2	3766	65.8	535
Female	103	44.0	131	56.0	29
New England	101	44.7	125	55.3	19
Mid Atlantic	423	37.2	714	62.8	96
E. N. Central	491	36.7	847	63.3	138
W. N. Central	185	38.5	296	61.5	35
S. Atlantic	249	31.1	552	68.9	62
E. S. Central	75	23.7	242	76.3	33
W. S. Central	230	29.0	564	71.0	75
Mountain	108	35.8	194	64.2	25
Pacific	300	37.0	510	63.0	92
GP	855	43.9	1091	56.1	179
FP	265	27.4	702	72.6	78
IM	201	28.2	513	71.8	76
OB GYN	212	32.7	437	67.3	67
Urology	67	39.9	101	60.1	9
Allergy	37	42.5	50	57.5	13
Derm	65	36.3	114	63.7	17
Psychiatry	59	17.8	272	82.2	30
DO	142	35.5	258	64.5	38
Other	360	34.9	671	65.1	108
No Age	253	39.8	383	60.2	67
No Sex	219	39.8	331	60.2	54
No State	117	38.9	184	61.1	43
No Specialty	16	45.7	19	54.3	3

QUESTION 5B

Will you continue to care for private patients who refuse to be a part of a nationalized medical system and want to pay their own bills?

	Yes	%	No	%	No Response
	5544	87.4	801	12.6	780
By Category:	**Yes**	**%**	**No**	**%**	**No Response**
Under 30	130	91.5	12	8.5	14
31 to 40	772	93.5	54	6.5	49
41 to 50	1242	90.3	134	9.7	89
51 to 60	1392	87.8	194	12.2	182
61 to 70	1111	80.6	267	19.4	290
Over 70	326	80.5	79	19.5	85
Male	4872	87.3	709	12.7	677
Female	189	83.3	38	16.7	36
New England	192	88.9	24	11.1	29
Mid Atlantic	980	87.9	135	12.1	118
E. N. Central	1128	86.8	172	13.2	176
W. N. Central	386	85.4	66	14.6	64
S. Atlantic	698	89.9	78	10.1	87
E. S. Central	278	88.5	36	11.5	36
W. S. Central	704	89.5	83	10.5	82
Mountain	249	85.0	44	15.0	34
Pacific	653	83.4	130	16.6	119
GP	1567	84.6	285	15.4	273
FP	862	90.6	89	9.4	94
IM	622	88.9	78	11.1	90
OB GYN	552	88.6	71	11.4	93
Urology	134	84.3	25	15.7	18
Allergy	81	91.0	8	9.0	11
Derm	157	87.7	22	12.3	17
Psychiatry	326	95.3	16	4.7	19
DO	351	86.9	53	13.1	34
Other	863	85.0	152	15.0	124
No Age	571	90.3	61	9.7	71
No Sex	483	89.9	54	10.1	67
No State	276	89.3	33	10.7	35
No Specialty	29	93.5	2	6.5	7

QUESTION 6B

Will you give up the profession of medicine and seek some other kind of work?

	Yes	%	No	%	No Response
	1606	28.3	4069	71.7	1450
By Category:	**Yes**	**%**	**No**	**%**	**No Response**
Under 30	46	35.1	85	64.9	25
31 to 40	218	30.3	501	69.7	156
41 to 50	406	34.6	768	65.4	291
51 to 60	386	27.8	1002	72.2	380
61 to 70	320	24.4	989	75.6	359
Over 70	81	20.1	321	79.9	88
Male	1426	28.5	3571	71.5	1261
Female	57	28.6	142	71.4	64
New England	53	28.5	133	71.5	59
Mid Atlantic	225	22.1	794	77.9	214
E. N. Central	349	30.3	803	69.7	324
W. N. Central	125	30.3	288	69.7	103
S. Atlantic	198	28.1	506	71.9	159
E. S. Central	70	23.8	224	76.2	56
W. S. Central	187	28.0	481	72.0	201
Mountain	77	31.0	171	69.0	79
Pacific	250	34.8	468	65.2	184
GP	478	28.9	1177	71.1	470
FP	207	24.1	652	75.9	186
IM	147	23.5	479	76.5	164
OB GYN	176	31.8	378	68.2	162
Urology	53	36.8	91	63.2	33
Allergy	16	21.9	57	78.1	27
Derm	31	19.4	129	80.6	36
Psychiatry	81	26.0	230	74.0	50
DO	102	29.3	246	70.7	90
Other	310	33.7	610	66.3	219
No Age	149	27.0	403	73.0	151
No Sex	123	25.7	356	74.3	125
No State	72	26.4	201	73.6	71
No Specialty	5	20.0	20	80.0	13

QUESTION 7B

Will you go into full-time medical work that will not require you to be responsible for patients' medical care?

	Yes	%	No	%	No Response
	2093	37.5	3481	62.5	1551
By Category:	**Yes**	**%**	**No**	**%**	**No Response**
Under 30	59	45.0	72	55.0	25
31 to 40	290	40.7	423	59.3	162
41 to 50	466	40.3	690	59.7	309
51 to 60	593	42.8	792	57.2	383
61 to 70	399	31.8	857	68.2	412
Over 70	75	19.5	310	80.5	105
Male	1828	37.3	3078	62.7	1352
Female	75	37.9	123	62.1	65
New England	80	41.9	111	58.1	54
Mid Atlantic	435	43.3	570	56.7	228
E. N. Central	471	41.4	668	58.6	337
W. N. Central	124	30.8	278	69.2	114
S. Atlantic	245	35.2	452	64.8	166
E. S. Central	82	30.3	189	69.7	79
W. S. Central	205	30.9	459	69.1	205
Mountain	74	31.0	165	69.0	88
Pacific	270	39.2	419	60.8	213
GP	557	34.3	1065	65.7	503
FP	331	40.2	492	59.8	222
IM	313	50.6	306	49.4	171
OB GYN	219	39.9	330	60.1	167
Urology	50	35.7	90	64.3	37
Allergy	24	34.3	46	65.7	30
Derm	39	23.9	124	76.1	33
Psychiatry	91	29.6	216	70.4	54
DO	118	33.4	235	66.6	85
Other	344	38.1	560	61.9	235
No Age	211	38.5	337	61.5	155
No Sex	190	40.4	280	59.6	134
No State	107	38.6	170	61.4	67
No Specialty	7	29.2	17	70.8	14

PUBLISHER'S REPORT

Truth in Medical News

The enemies of medicine seem to believe that doctors can go on giving first-class treatment to their patients no matter what. But the continuing attacks upon our profession *are* having an effect.

I do not believe, however, that any assault on physicians would be significant if it were not grabbed by the news media and blown up out of perspective. Let one person attack our profession before a Congressional committee, and it makes national news; let one person submit documentary evidence about the greatness of our profession, and it doesn't even make the obituary page.

With the power of television, radio, and newspapers, the media can destroy anything they focus their attacks on. The Corvair — a safe automobile — was driven off the market. No one is immune. Even President Lyndon Johnson — *sans* Watergate — could not withstand them.

The attacks on doctors, hospitals, and the drug industry have been severe for more than twelve years, although they started in the early 1940s. The wonder is that our profession is able to deliver as good medical care for our patients as we do.

I do not say that our profession is without faults, but we have been so busy defending our freedom and our existence that we have not had much time to work on the improvement.

What is the answer to this problem? First, let me emphasize that I do not advocate laws to hinder the news media from printing whatever they wish. I do not believe this is the proper function of government anymore than I think it is government's business to provide medical care.

America has about 2,000 daily newspapers and 7,000 weekly ones, along with a lesser number of TV and radio stations. But there are over 300,000 doctors and 1,900 county medical societies. A Truth in Medical News Committee composed of doctors and their wives, for every newspaper, TV and radio station in this nation, could turn the tide of adverse publicity.

Equally important: drug firms, hospitals, insurance companies, doctors, and patients who believe in the principles of our profession should put their money and efforts into only those institutions that support quality medical care through private practice physicians.

On page 13 of this issue, there is a report on our survey of doctors about National Health Insurance. These alarming facts should be communicated to our patients through every means available. Take a copy of this report to your local newspaper, radio, and TV station, and ask their help in telling the people what will happen to quality medical care in America if National Health Insurance is enacted. ☐

Francis A. Davis

Francis A. Davis, MD

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The Assumptions Behind Political Medicine Are False!

* * *

A Study of the Truth
by
Donald Quinlan, M.D.

Submitted to:

Health Subcommittee,
House Ways & Means
Committee
September 12, 1975

I thank this Committee for providing the opportunity to give you my views on so-called National Health Insurance — which, of course, isn't insurance, but a governmental taxation and control scheme.

I am Donald Quinlan. I'm engaged in the practice of private medicine in Chicago, Illinois. I was educated in Ireland, England and Switzerland, and served from 1948 to 1953 in general practice under the British National Health Service. I emigrated to the United States in 1958. Since then I have obtained additional resident training, and United States citizenship. I have practiced in Chicago since 1960 as a specialist in internal medicine. My professional time is totally devoted to the ethical care of patients, and defending the right to such practice.

After reviewing the debate in this country on this subject, and considering my experience both here and abroad, I have decided to discuss the subject under three headings:

I. ***Compulsory Politicalized Medicine*** — a description used in preference to the misleading and inaccurate term National Health Insurance;

II. ***Prepaid Per Capita Group Practice*** — used instead of the misleading label Health Maintenance Organizations (HMOs) used by its proponents;

III. ***Devices for Government Dictation and Control*** — which are deceptively referred to by their proponents and apologists as Utilization Review and Professional Standards Review Organizations (U/R and PSRO).

The latter two items are actually a part of the whole scheme to nationalize medicine. But, since the HMOs and PSROs have been the subjects of separate acts of Congress — even though the planners see them as a part of the whole drive to politicalize medicine, and defraud free citizens of their birthright — they should be dealt with separately.

Compulsory Politicalized Medicine

Most so-called National Health Insurance proposals both here and abroad — in non-communist countries at least — are based upon the following assumptions:

- That ordinary law abiding citizens who are competent to vote and make choices among competing candidates for public office are considered incompetent to make proper choices for their own medical care in a free market and, therefore, should be denied the right to choose where, when, how and by whom they should be treated.

- That all citizens should have a part of their earnings forcibly taken from them by government and spent for medical care and that, as a consequence, government agents should directly interfere with the physician's judgment while he is treating the patient.
- That government agents are more capable and competent than ordinary citizens and even more capable and competent than the attending physician who supplies the service.
- As a corollary, that where patients are at liberty to select the physician and hospital of their choice both the physician and hospital will unethically, inappropriately and unnecessarily provide medical care that the patient does not need.
- That the normal behavior of physicians now caring for patients should be changed by government agents so that doctors' actions uniformly conform to undefined behavior goals of these government agents.
- That the most important element of a person's health is the kind of medical care he receives.
- That everyone has a definable need for medical care that government can identify and provide at reasonable cost and satisfaction to patients if only physicians and other suppliers of services will subordinate themselves to dictation and control through mechanisms devised and employed by a centralized bureaucracy.
- That if government controls the provision of medical care, quality will rise, costs drop, and more satisfactory care will be available for everyone.

I not only challenge these assumptions as being false and unwise, but also challenge the bureaucracy and its supporters in the Congress to clearly delineate where the authority exists in the United States Constitution for such unreasonable and arbitrary dictation and control. I mean by this that the proponents of such a program have the burden of proving that it was the intention of the Framers of the Constitution to deny patients the freedom to choose their own doctor or hospital.

With respect to people's capabilities, obviously, if citizens are competent to vote in a society that presumably is based upon self-government with emphasis on the self, then they should be considered competent to obtain their medical needs on their own initiative without governmental paternalism and interference.

NEITHER THE RECORD in this country nor any other country will sustain the assumption that government agents are better qualified to determine the medical needs of citizens than the citizens themselves. For any person who wants to seriously examine whether politicalized medicine in any form is better or more desirable than free-choice medicine, he should read the book *Medicine and the State* by Lynch and Raphael who have done the most objective job of examining the claims of the proponents of politicalized medicine and thoroughly discrediting it as a desirable method of meeting the needs of patients.

The proponents of subsidy and control habitually accuse physicians of unethical practice, such as unnecessary surgery on a wholesale scale. The evidence does not support these charges. In fact, it has become an accepted tactic of the government interventionists to snatch figures out of the air with no basis whatever in fact and to otherwise falsify the record simply to discredit doctors and create a false picture of a need for government action.

The changing of behavior of physicians as a goal of the bureaucrats may come as a surprise to some legislators, but those of you who don't think this is substantiated should read the Brookings Institution Report of 1972 entitled *Setting national priorities — the 1973 Budget* and, particularly, Chapter 15 entitled "A New Approach to Priorities" in which it is arrogantly assumed that it is the proper province of government bureaucrats and their allies in the academic community to use government force to change the behavior of everyone. If anyone is still in doubt, I commend to your attention the draft of the *PSRO Program Evaluation Plan* developed by HEW bureaucrats. The idea, alien to America, to use the power of government to force behavior changes is clearly set out in this document as a goal of the PSRO program.

Of course, it is patently false that medical care is most important to health. Many people have lived to be 70, 80 or 90 years of age without having once seen a doctor. It is obvious that the most important factors for good health are food, water and air and ancestors with a history of longevity. It is also obvious that the ordinary individual can have much greater control over his health than can any private doctor at liberty to do his best for his patient or even more so than by a doctor smothered by government red tape and inhibited by bureaucratic interference. The health of millions of people who abuse their bodies and minds by excessive smoking, eating, drinking and by other intemperate actions is not going to be improved by politicalizing medicine. Likewise, the millions of injuries through automobile accidents will not be reduced by denying to the people free choice of physician or hospital or otherwise treating them as government wards as far as medical care is concerned.

The assumption that government is capable of defining medical needs and satisfying them is contrary to the experience of people who have tried to make socialized medicine work only to find that it is inherently unworkable. This false assumption and others I have mentioned will be further elaborated upon during the course of this discussion.

COST: I suggest that the Committee should recognize that government cannot give everyone everything they want and that if it attempts to do so, it will surely decrease, rather than increase what is available to sustain life, liberty and the pursuit of happiness.

The cost of politicalized medicine to government and the people is more than Congressmen should force their constituents to pay. And when their constituents find out the truth, they are going to rebel.

Not only is the cost of politicalized medicine in money too high but its price in denial of individual liberties is unconscionable. Most people, in this country at least, treasure liberty as highly as they do anything else. Liberty is severely impaired by politicalized medicine and the record shows that to be true. Let's first deal with the raw money or dollar cost of political medicine and see why the evidence shows that it is far, far too high.

Not only (1) do the bureaucrats admit that political medicine is too costly, but (2) experience with Medicare and Medicaid since 1966 proves it, and (3) clearly the Kennedy-Corman bill would more than bankrupt the United States and the evidence is conclusive.

> With respect to the bureaucrats admitting that political medicine is too costly, they have stated that *"The Medicare and Medicaid programs are in serious financial trouble. The two programs are also adversely affecting health care costs and financing for the general population."* Quite illogically they conclude that *"Unless the rapid and continuing escalation in the costs of health care are moderated, the Congress .may reasonably anticipate increasing pressures upon it to extend the Medicare and Medicaid programs."* This absurdity is a horrible example of bureaucratic rationale. (See Senate Committee Staff Report, Medicare and Medicaid Problems and Issues, February 9, 1970, Pages 1 and 2.)

The bureaucrats attempt to lay the blame on physicians and hospitals but the real blame lies upon the heads of the politicians who opened Pandora's box by promising millions of people medical care at less than the market cost. Any time any group of people are promised something at less than cost at the point of consumption, the demand is infinite.

The Honorable J. Enoch Powell, British Minister of Health 1960-1963, who tried to make the British National Health Service work, said in his book *A New Look at Medicine and Politics* that: *"Under the National Health Service care is rendered free to the consumer at the point of consumption. Consequently supply and demand are not kept in balance by price. Since, therefore, resources are limited, both theoretically and in practice at any given time, or the demand is unlimited, supply has to be rationed by means other than price. The forms of rationing adopted deliberately or by default, and usually unrecognized, certainly unproclaimed as such, are among the major irritant ingredients in Medicine and Politics."*

He goes on to say: *"Common thought and parlance tend to conceal or deny the fact that demand for all practical purposes is unlimited. The vulgar assumption is that there is a definable amount of medical care* *'needed,' and that if that 'need' was met, no more would be demanded. This is absurd."*

And he explains why. *"There is a characteristic of medical care that makes its public provision exceptionally problematic. The demand for it is not only potentially unlimited; it is also by nature not capable of being limited in a precise and intelligible way."*

He then adds that: *"The National Health Service, then, must and does apply covert rationing devices in order to limit demand to the actual amount of the supply."*

THE BUREAUCRATS in the United States are trying to make it appear that the doctors are responsible for the costs of the actions of the politicians. In Britain, the government is rationing medical care by making patients wait for the promised services. The bureaucrats here are trying to tell the patients that they can have whatever their heart desires and that if they don't get it, it is the doctors who are keeping them from getting it. This is what all of the elaborate bureaucratic machinery with respect to utilization review and PSRO is all about. It is impossible for an ethical doctor to put the patient's interests first and, at the same time, be an agent of government responsible for artifically holding down demand. It is Congress that is at fault for having promised to give patients something for nothing. This causes the well and the worried-well to usurp physicians' time that should be devoted to the truly ill. Doctors are not policemen and when they try to exercise the role of policeman they are no longer doctors.

> Experience with Medicare and Medicaid since 1966 shows that political medicine is too costly.
> What is the evidence?

First and foremost, the bureaucrats solemnly assured the Congress, (the Ways and Means Committee, in fact) that hospitalization under Medicare the first year would cost $900 million(1). Actually, the first year cost was $2.7 billion(2). They pledged that it would cost no more than $1.4 billion the fifth year. Actually it cost $5 billion(1, 2). They said that after the 10th year it would cost $1.7 billion and it is actually costing $10.9 billion(2). The first year cost was three times as much as bureaucrats said it would be and the 10th year cost has

(1) Actuarial Study, No. 57 by HEW, July 1963.
(2) U.S. Budget, Special Analysis, FY 1975, 1976

soared to over six times as much as they promised.

These expenditures are absolutely indefensible. But is is unconscionable, irresponsible and wrong to place the blame on the doctors; it is wrong to place the blame on the hospitals. The proper place to fasten the blame is on the Congress and the bureaucrats who were instrumental in the enactment of the Medicare and Medicaid laws. Medicare and Medicaid have helped skyrocked HEW expenditures. HEW, in the fiscal year 1976, will spend over $118.4 billion(2). This is more than all of the spending for military defense. It is more than all the profits after taxes of all the corporations in the United States. It is more than all the personal savings of all the people in the country.(2, 3, 4)

The record shows that in 1974 federal spending for medicine and health was $28.3 (5) billion and that was more than twice as much as expenditures by the states. This is significant because responsibility as exists in government for the people's health which was properly delegated to it resides solely in the state and local governments and not in the federal government. But because this power has been usurped by the federal government, HEW expenditures have contributed mightily to inflation. A dollar that a person saved in 1940 is now worth only 24 cents (6). A dollar that a person saved in 1967 is now worth only 64 cents(6). This arithmetic of cost comes from government documents. This means that since 1940, over three fourths of the value of the dollar has been deceptively taken by government. And over one third the value of the 1967 dollar has thus been stolen from the citizen by irresponsible government (6).

In 1940, 25% of everything everyone earned in the United States was taken and spent by local, state and federal governments(7). That figure climbed to 48% in 1974(7). The fact that this has been hidden from the people is the reason they wonder why the prices at the grocery store and at every other place where people buy things have gone up through the roof. The answer is that a tax on a tax on a tax, from the raw material through every stage of processing, is gouging everyone. Certainly, it is gouging the elderly, the widows who are living on fixed incomes and the poor who cannot vote themselves, as Congressmen have done, income which is protected from the escalation in inflation. The plunder through the Congress and bureaucracy is scandalous and must stop.

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(2) U.S. Budget, Special Analysis, FY 1975, 1976

(3) Survey of Current Business, April 1975

(4) Testimony of AAPS on the 1976 HEW Budget to House Appropriations Subcommittee on Labor, HEW, May 14, 1975

(5) Social Security Bulletin, Jan. 1975

(6) Calculated from Consumer Price Index, Bureau of Labor Statistics

(7) Statistical Abstract U.S. 1974; Survey of Current Business, Feb., 1975

THE PROPOSED Kennedy-Corman bill would drive this country into bankruptcy. The HEW bureaucrats who are for complete politicalized medicine for everyone in this country say that it will cost $129 billion. If we apply the understatement of the bureaucrats who promoted Medicare and Medicaid to this bureaucratic estimate of the cost of the Kennedy-Corman bill, it would probably cost the first year not $129 billion but $388 billion. This should be compared with the fact that during the current calendar year total federal expenditures for all purposes are only $299 billion(8). If the estimates of the bureaucrats for the 10th year for the Kennedy-Corman bill turn out the same as they did for Medicare, then the 10th year would cost $829 billion. These figures are so incomprehensible that they need to be translated. This is what you need to know and this is what your constituents should know — and to the extent that this information can be communicated accurately to the electorate, it will be done.

The present cost per family of four for all the expenditures now by local, state and federal governments and for private medical care, is $1,968 per year(9). The HEW estimate of the Kennedy-Corman bill would raise that to $2,400 per year. But if allowance is made for the understatement of the bureaucrats, on the same basis that they understated the cost of Medicare, then the first year of Kennedy-Corman would cost a family of four $7,136. Compare this with the average annual earnings of workers as of April, 1975 — only $8,031 This is bankruptcy.

John Maynard Keynes, a Fabian-Socialist economist whose disciples have misled the free world into destructive deficit government spending that has caused inflation to rage in Great Britain and threatens to destroy responsible self-government in the United

(8) H.E.W. Testimony, 7/74
(9) Survey of Current Business, 4/75

States, recognized, however, that inflation was a deadly trap. In his book, written soon after World War I, *The Economic Consequences of the Peace*, beginning on Page 235, he said:

> *"Lenin is said to have declared that the best way to destroy the capitalist system was to debauch the currency. By a continuing process of inflation, governments can confiscate, secretly and unobserved, an important part of the wealth of their citizens."*

Then, he added:

> *"Lenin was certainly right. There is no subtler, no surer means of overturning the existing basis of society than to debauch the currency. The process engages all the hidden forces of economic law on the side of destruction, and does it in a manner which not one man in a million is able to diagnose."*

According to the Budget of the United States, the public debt of the United States at the end of this fiscal year is expected to reach an incredible $596 billion(10). Incredible as that is, you should realize that since the Department of Health, Education and Welfare was organized as such in 1958, its expenditures have totalled a mind-boggling $682 billion(11). It is instructive in the light of Lenin's drive for state monopoly capitalism that the Department of Health, Education and Welfare publishes from time to time charts showing the expansion of public spending and the complementary contraction of private spending for health care. They point out clearly the inexorable direction in which more government spending and control is leading us.

If anyone doubts that this course will bankrupt us, then I suggest he study the evidence very carefully because it is abundantly clear that government plunder(12) through medicine and other devices must stop if we are not to destroy liberty in this country.

There are those who scoff at the possibility of the United States government going bankrupt. Past apologists for the bureaucratic excesses of New York City scoffed at it going bankrupt, but it is.

Government after government is beginning to realize that government spending must be controlled. The budget deficit which this country now faces of $60 billion for this year alone is an outrage. Stoking the fires of inflation by bureaucrats and then passing laws to insulate the bureaucracy and the Congress from the direct effect of the inflation by an automatic cost of living escalator, could be the spark that burns the pants off all politicians disguised as Santa Claus and expose them for what they are — thieves in the garb of benefactors. This great rip off is not going unnoticed, and if the rip off of denying patients the right to their own earnings and to willingly choose the doctor and hospital they desire is exposed to the electorate, it just may be that enough citizens will become so infuriated they will start spending more of their waking hours out in the precincts doing the kind of job that should be done to put in power a responsible set of legislators instead of a group dedicated to plunder (12) without regard to its disastrous effect.

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(10) U.S. Statistical Abstract, 1974; U.S. Budget, FY 1976

(11) ibid #10; Library of Congress

(12) *The Law* by Bastiat

PREPAID PER CAPITA GROUP PRACTICE

Evidence abounds that the frenetic campaign to sell HMOs to the American people is doomed to failure. Why? Because it's a concept that doesn't fit the average American's idea of how he wants to obtain medical care. Most people want the kind of personal relationship — a relationship of trust and confidence — that can only grow over a period of time under treatment by the same doctor. They want the right and the privilege of choosing their own doctor.

HMOs, once known as prepaid or closed-panel group practice until someone tagged them with the fraudulent name of Health *Maintenance* Organizations, have not been what you would call a smashing success in this country. In fact, the only significant dent they have made on the medical scene has been in those cases where the clientele has been chiefly captive members of labor unions.

The ill-advised and irresponsible program of the Congress to force HMOs on the people by the use of their tax money for massive HMO subsidies is an acknowledged failure. And still, the push goes on for bigger subsidies and for more concessions in a desperate and reckless hope that this idea will catch fire with the American people.

(12) *The Law* by Bastiat

It's obvious they aren't buying it. Don't you get the feeling that there is a motive here other than a genuine desire to improve the nation's health care? Or to save money?

In the first place, there is not a shred of provable evidence that prepaid group practice costs less than fee-for-service, private practice medical care for the same service or that patients of these groups are healthier and live longer than the rest of the comparable population.

There is sobering evidence, on the other hand, that elimination of fee for service, in fact, disrupts medical care to the detriment of the truly sick. Dr. Sidney R. Garfield, considered the father of the Kaiser-Permanente program, explained it this way in a *Scientific American* article in 1970:

> *"Only after years of costly experience did we discover that elimination of the fee is practically as much a barrier to early sick care as the fee itself. The reason is that when we remove the fee we remove the regulator of flow into the system . . . The result is an uncontrolled flood of well, worried-well, early-sick and sick people into our point of entry — the doctor's appointment — on a first-come, first-served basis that has little relation to the priority of need . . . The impact of this demand overloads the system and, since the well and worried-well are a considerable proportion (of patients), the usurping of available doctors' time by healthy people actually interferes with the care of the sick."*

It will be well to keep in mind, also, that with an HMO type setup there is a built-in incentive to deny medical care to patients. That's because under a system in which money is paid in advance for prospective services, the patient who actually receives the service is a liability; the patient who can be kept away or does not of his own accord show up is an asset.

Now, set that fact in the context of a network of HMOs across the nation controlled by a coterie of HEW bureaucrats who are charged with the responsibility of controlling costs.

HMO ENROLLEES will pound the HMO doors for treatment of every tiny complaint. After all, haven't they been told by a chorus of voices from the left that health care is a right? As the flood of well and worried-well that Dr. Garfield spoke about rises, costs soar and soar and soar. How will the bureaucrats react? They can't blame unconscionable doctors' fees (one of the current knee-jerk reactions) because doctors will be on salary and under control of bureaucrats or will be on contract. So, HEW employees will have to decide that health care isn't a right after all, and they will do what they have to do — convert patient liabilities into patient assets by denying demands for medical care or establishing long waiting lines like they have in Britain.

Care will have to be rationed for those patients unfortunate enough to have abandoned freedom of choice for the false lure of the HMOs in the belief that all their medical needs and demands would be satisfied for a fixed fee paid in advance.

What I and a lot of other people would like to know is why members of Congress, the elected representatives of the people, continue to insist on picking the taxpayers' pockets to pour more money into a program that the people have convincingly demonstrated they don't want. Is the motive a passion to give government another weapon in the continuing campaign to control doctors and obliterate the practice of private medicine in America?

The promotors of the HMO scheme cannot be ignorant of the facts.

The *Wall Street Journal* surveyed the HMO scene across the nation in February, 1975, and found that numerous insurance companies and other organizations had abandoned plans to start HMOs simply because too many that had been started had failed. The reason? In these cases, the people just were not interested. But the failures of HMOs are not based solely on lack of interest by prospective patients.

For example, the story of government-subsidized HMOs in California (called Prepaid Health Plans) should be enough to dampen anyone's enthusiasm for the scheme. It's a story of fraudulent sales practices, denial of promised services, waste, excessive costs, and bureaucratic bungling. The Legislative Audit Committee of the California Legislature also discovered that not only were the state's indigent being shortchanged on service, the taxpayers were being shortchanged on cost. The committee found that the 15 PHP contractors were pocketing 52% of the money paid them by the

Department of Health to provide health care for the poor.

The continued campaign to pick the taxpayers' pockets to force on the American people the HMO scheme they clearly don't want can hardly be described as responsible legislative action. I view it as more than that — I view it as another aspect of the relentless drive to subjugate physicians and the public to the control of government bureaucrats.

> *This unconscionable disposition on the part of some congressmen to try to buy votes by promising free medical care to everyone on the pretext of helping improve medical care while reducing its cost is patently a political fraud. If you want to debase the quality of medical care and drive up its cost, and degrade the people in the process, turn the nation's health care over to government bureaucrats.*

DEVICES FOR GOVERNMENT DICTATION AND CONTROL

Government controls through so-called Utilization Review and subsidization through PSRO are particularly objectionable and unacceptable to any person who believes in individual liberty, provided he is sufficiently wise to know that government controls to justify subsidies is the baited trap of tyrants. An old con man once told me that the first step in taking a sucker is to put thievery in his heart. The bureaucracy and its partners are doing just that in utilization review and PSRO as well as HMOs.

As I said earlier, utilization review and PSRO are the devices of Congress and the bureaucracy by which they proclaim that physicians and hospitals are to blame for the skyrocketing costs of medicine. The primary cause, however, is political promises which cannot be fulfilled. My comments on costs cover that point.

Politicians justify government interference on the premise that the federal government is subsidizing health care and government can properly control anything it subsidizes (Wickard vs. Filburn in 1942, 317 U.S., p. 131).

The excuse for imposing controls is that: "The costs of the Medicare and Medicaid programs have skyrocketed far beyond the early estimates (government estimates). In this fiscal year alone, Medicare and Medicaid will cost the federal and state governments some $19 billions."

The legislative and executive branches of the federal government are blaming physicians for these skyrocketing costs. For example, the Senate Committee Report on this legislation said:

> *"The rapidly increased costs of these programs (Medicare and Medicaid) are attributable to two factors. One of these is an increase in the unit cost of services, such as physicians' visit, surgical procedures and hospital days. The second factor . . . is an increase in the number of services provided to beneficiaries. Witnesses (not identified) testified that a significant proportion of the health services provided . . . are probably not medically necessary. Unnecessary hospitalization and unnecessary surgery are not consistent with proper health care."*

Through the PSRO Sections of this law, politicians are making it appear that "practicing physicians" are being given "full responsibility and authority" to keep costs from skyrocketing.

This is a double-barrelled deception.

First — Political promises and excessive government spending are the primary causes of increasing costs, not the actions of physicians. Physicians are caught in the upward spiral of inflation along with everyone else.

Second — Physicians are not being given responsibility and authority to control costs through PSROs because such authority as this law provides is strictly in the iron-handed control of the Secretary of HEW and his employees. But, even more important, neither he nor his employees have power to control costs effectively.

It is ridiculous for physicians to feel guilty about these increasing costs for which politicians are responsible. Likewise, it is ridiculous for physicians or physicians' organizations to accept responsibility for holding down costs, which they cannot do. Costs will continue to skyrocket regardless of whether physicians do or do not collaborate in this PSRO scheme.

However, physicians' organizations which do collaborate will betray physicians because as costs continue to inflate, and every reasonable person knows they will, politicians will keep shifting the blame from themselves by saying: "We gave the physicians and organized medicine responsibility to hold down spending and they failed — therefore, we must force them into complete nationalized medicine." This they are clearly planning to do. (See *PSRO: Organization for Regional Peer Review* by Decker and Bonner.)

> *With all the restrictive laws Congress has passed affecting medical care and all the oppressive regulations imposed by HEW as a result and all the additional restraints on medicine contemplated by legislators, the government is rapidly becoming the biggest barrier to quality health care in America.*

THIS COMMITTEE should know that the Association of American Physicians and Surgeons filed suit in June, 1973 against the Secretary of HEW to have declared unconstitutional the law passed by Congress in 1972 which provides for imposing federal standards and limitations on the manner in which private physicians diagnose, treat and care for patients who are beneficiaries under the Medicare and Medicaid program. The PSRO law gives the Secretary authority to impose a system of pre-set regional "norms" describing what is to be considered "appropriate" diagnosis and treatment of particular illnesses and health conditions to determine whether the services rendered by a physician (or hospital) are medically necessary and carried out in a most economic facility.

The legislation in question signals the first extension of federal authority to the control of the substantive aspects of medical practice through the imposition of prior and concurrent restraints upon physicians' professional medical judgments and practices in treating their patients.

This suit is now on appeal to the Supreme Court of the United States.

Members of Congress and the HEW bureaucracy must recognize that this suit challenging the constitutionality of the PSRO law reflects the determination of the membership of that Association to take whatever legal action is warranted to protect patients and physicians from government interference.

In this lawsuit, the Association is asking the courts to determine whether "continuous national administrative direction, regulation and control of a physician's judgments concerning the diagnosis, treatment and care of his patients unduly interferes with the constitutionally protected rights of both physicians and patients." The brief points out that the Supreme Court in other cases has recognized there is a constitutionally protected right in the physician-patient relationship.

That is the basic question involved in this lawsuit, and AAPS is charging in its appeal to the Supreme Court that the District Court was grievously in error in its interpretation of the clear provisions of the PSRO law.

The district court's conclusion that appellants' complaint failed to state any claim for relief is based principally on the profoundly misconceived notion that the legislation in question was enacted merely to provide "standards for the dispensation of Federal funds" to physicians, the strictures of which they are free to endure or not as they see fit, and that, consequently, any question as to its constitutionality is laid to rest merely by a determination that the law is reasonable in relation to its subject matter and does not create discriminations that are patently arbitrary or totally lacking in rational justification.

IT IS IMPORTANT to note at the outset that the district court has misunderstood the role of physicians in the Medicare-Medicaid programs. Physicians do not receive payment under these programs as public contractors or employees, and their participation in the programs does not constitute a submission to any of the regulatory authority commonly incident to such contractual arrangements. Benefits under the Social Security Act are payable to, or on behalf of, the persons eligible for them. (42 USC 1395d, 1395k.) It also is important to realize that physicians will not be able, in any meaningful sense, to avoid the impact of the law by refusing to treat Medicare-Medicaid beneficiaries, as the district court appeared to believe.

Members of the Congress should note that AAPS also alleges that the Congressional decision to enact PSRO was not warranted by any compelling public interest.

Members of the AAPS adhere to the principle — and hopefully the Supreme Court will agree in this case as it has in others — that a physician has a right to practice his profession free from arbitrary government interference. And arbitrary, unwarranted government interference is the essence of PSRO.

The lawsuit of the AMA to enjoin the Secretary of HEW from imposing utilization review regulations issued on November 29, 1974 involved the same arguments as the AAPS in its PSRO lawsuit.

Utilization Review interferes with the best professional judgment of the attending physician in the same manner as PSRO. The UR regulations of the Secretary of HEW of November 29, 1974, which was enjoined by a Federal District Court and upheld by a Federal Court of Appeals, in fact asserted that:

> *"In developing final regulations to use the authority of and to implement section P.L. 92-603, care has been taken to assure that these regulations (UR) are supportive of the implementation of the PSRO program and consistent with approaches to be employed for PSRO review of hospital and skilled nursing facility care. Accordingly, these amendments provide that utilization review in hospitals shall employ a system of concurrent review . . ."*

SUMMARY OF COMMENTS

Compulsory politicalized medicine, misleadingly termed National Health Insurance, cannot be instituted for all citizens without destroying the free-choice willing exchange system upon which the success of America is based. Congress should exercise restraint and not plunge further into the morass of more subsidy and more control which is compulsory politicalized medicine. The principle which should be honored is that such government intervention as is necessary in medicine should only be performed by state and local government. And the unsound argument that some people are being denied adequate medical care because federal funds are not available to buy everyone's medical care should not be used as an excuse to destroy our system. The whole concept of the necessity of central government to pay for preventive care, well baby care, examinations, immunizations and innoculations, out-patient psychiatric care, x-ray and laboratory work is absurd on its face. Local government can do what is necessary where individuals are incapable of handling their own problems in these regards. the whole trap of equality of benefits for the employed and unemployed should be avoided. There should no no national requirement that employers provide any particular type of coverage for their employees. States are fully capable of handling such problems. It is inconsistent to endorse voluntarism and then subscribe to an elaborate detailed mechanism of compulsion. Compulsory politicalized medicine is too expensive in dollars and in bureaucratic inroads against individual liberty.

Prepaid per capita group practice, misleadingly termed Health Maintenance Organizations, is merely a part of the drive for compulsory politicalized medicine and should not be subsidized and controlled by the federal government.

Government intervention creates distortions and adverse consequences far beyond the average person's capacity to comprehend at the time the law is initiated. One of the consequences that is only dimly perceived now but which is coming into sharper focus in countries where politicalized medicine exists is that the doctor-patient relationship is seriously impaired. For the physician to care for a patient to the maximum of his ability, he needs the trust and confidence of the patient. Whenever government intrudes, it forces the physician to cease giving his undivided attention to the welfare of the patient and diverts his attention to the demands of a calloused bureaucracy which insists upon him doing what the bureaucracy wants rather than what the doctor thinks is good for the patient. Personally, I want my doctor to have a stake in my welfare undiluted by any conflicting loyalty or subservience to government agents.

The devices of government dictation and control, deceptively referred to as utilization review and Professional Standards Review Organization, are against the interests of patients and physicians alike and should be eliminated.

The United States should build upon the knowledge available from past experience in this country and abroad where the evidence is clear that compulsory politicalized medicine contributes to inflation. And mark you well, inflation can destroy our system in the United States as it has been used to destroy other free choice systems in other areas of the world.

Also, I devoutly pray, a parasitic system of compulsory politicalized medicine will not be allowed to drag this nation down into the quigmire of socialism as it has done in most other areas of the world. If it does, where will men go who believe in the liberty of the individual to live as his conscience dictates so long as he refrains from affirmatively inflicting injury upon his fellowmen?

You, the members of Congress, have the power to protect liberty and justice in America, but the question is "Will you be statesmen enough to do it in the face of the sophistry, self-pity and clever efforts to further plunder the people in the disguise of being a political Santa Claus?"

"A NEW LOOK AT MEDICINE AND POLITICS"

by

The Right Honorable J. Enoch Powell,
British Minister of Health - 1960-1963

The following are excerpts from
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INTRODUCTION

Since medicine has become inextricably involved with politics, and the organization of medical services sometimes seems to have assumed more importance than the quality of those services, a new look at medicine and politics is badly needed. Few people can be better equipped to supply this new look than an ex-minister of health.

We may sometimes regret the days when the doctor, G.P. or specialist, was the independent practitioner of a highly skilled art, answerable to no one but his own conscience and the corporate conscience of his colleagues for the standard of the care he gives his patients, and asking — and very often waiving — a direct monetary return for his services. Now, since the National Health Service, the hospital doctor is a State employee and the general practitioner is a contractor to the State. Such a change in the setting of medicine is fraught with profound consequences, which are still only gradually being explored and understood. These consequences are widely misunderstood, by profession and public alike, as being accidental or transitory or easily remedied, due perhaps to the weakness of a particular Minister or the faults of a particular government. Mr. Powell shows that this is not so. The strains and stresses, the inadequacies and dissatisfactions, which the profession and the public experience, are implicit, he argues, in the nature of a free, comprehensive national health service itself. (From the introduction to *Medicine and Politics*)

PUBLIC MONEY

"The necessity which is proverbially the mother of invention is least fecund when she is presented in the guise of his majesty's treasury." p. 20.

"Financing of a service by the public and especially Exchequer money converts every limit upon demand into an arbitrary and perverse or even malevolent decision imposed by conscious authority." p. 20.

"In a publicly financed service, remuneration of the employee is seen as an arbitrary evaluation placed upon people and their work by a political authority." p. 21

"But the moment the employer or the paymaster is the Exchequer, it is assumed that he has the power to pay more at will, and so what is actually paid or offered, is treated as a deliberate evaluation of the employee by the employer, and resented accordingly." p. 21.

"You do not hear artists, or clergymen, or monks, or missionaries, or actors, or novelists complaining that their sense of vocation is being exploited. Nor did the doctors or the nurses or the dentists do so before the Exchecquer became paymaster." p. 23

"With the medical profession, . . . the supply can adjust itself to change in demand only after a more or less substantial interval of time." p. 24.

SUPPLY AND DEMAND

"(In NHS), supply and demand are not kept in balance by price. Since, therefore, resources are limited, both theoretically and in practice at any given time, or the demand is unlimited, supply has to be rationed by means other than price. The forms of rationing adopted deliberately or by default, and usually unrecognized certainly unproclaimed as such, are among the major irritant ingredients in Medicine and Politics." p. 26.

"Common thought and parlance tend to conceal or deny the fact that demand for all practical purposes is unlimited. The vulgar assumption is that there is a definable amount of medical care 'needed', and that if that 'need' was met, no more would be demanded. This is absurd. Every advance in medical science creates new needs that did not exist until the means of meeting them came into existence, or at least into the realm of the possible. For every heart-lung machine or artificial kidney in operation there must be many times that number of cases to which the treatment would be applicable. Every time a discovery is made in, for example, the techniques of grafting, the horizon of 'need' for medical care is suddenly enlarged." p. 26.

"There is a characteristic of medical care that makes its public provision exceptionally problematic. The demand for it is not only potentially unlimited; it is also by nature not capable of being limited in a precise and intelligible way." p. 28.

"The National Health Service, then, must and does apply covert rationing devices in order to limit demand to the actual amount of the supply." p. 29.

"It is a common error to suppose that a cash relationship is inconsistent with mutual respect between professional and client, or is synonymous with selfishness or irresponsibility. A glance at any of the non-nationalized professions proves the contrary. The question is rather whether a tolerable and satisfactory relationship between general practitioner and patient can exist when there is no cash nexus." p. 35.

". . . good and bad service (in similar circumstances) are remunerated at one and the same price. A capitation fee can no more distinguish between good and bad service than a fee per item of service, which governments have consistently rejected." p. 37.

"Thus, outside as well as inside the hospitals the figure on the supply side of the equation is fixed at any particular time by those complex forces that determine that state's decisions on expenditure. With this figure demand has to be brought into balance. Virtually unlimited as it is by nature, and unrationed by price, it has nevertheless to be squeezed down somehow so as to equal the supply. In brutal simplicity, it has to be rationed; and to understand the method of rationing is also essential for understanding Medicine and Politics. The task is not made easier by the political convention that the existence of any rationing at all must be strenuously denied. The public are encouraged to believe that rationing in medical care was banished — being applied to medical care is immoral and repugnant. Consequently when they, and the medical profession too, come face to face in practice with the various forms of rationing to which the National Health Service must resort, the usual result is bewilderment, frustration and irritation. The worst kind of rationing is that which is unacknowledged; for it is the essence of a good rationing system to be intelligible and consciously accepted. This is not possible where its very existence has to be repudiated." p. 37 & 38.

"There has to be some differential rationing for different qualities of an article, and if not price, then, for example, time: better surgeon, longer wait, and vice versa." p. 39.

"I cannot but reflect sardonically on the effort I myself expended, as Minister of Health, in trying to 'get the waiting lists down'. It is an activity about as hopeful as filling a sieve, although this is not to deny that some of the measures applied and pressures exerted might conceivably have had some useful side-effect in improving, in a slight degree, the direction of effort. There were the circulars enjoining such devices as the use of mental hospital beds and theatres, or of military hospitals. There were the stiff cross-examinations of staffs and hospital authorities in the endeavour to discover what contumacy might explain their continued non-compliance with the official exhortations. There were the special operations to 'strafe' the waiting lists, urged on the fallacious ground that a stationary waiting list is not evidence of deficient capacity — otherwise it would lengthen — but of a backlog which, once 'cleared off', ought not to be allowed to recur." p. 40.

"Alas, the waiting list that melted under an assault of this kind was back again to normal before long. There were always special, local and temporary explanations that could be cited, such as a sudden coincidence of staff off duty through leave, sickness or change of post. But all too evidently the causes at work were general and deep-seated. There was a mean around which the figures fluctuated, but that was all. Naturam expellas furca tamen usque recurret: though you drive Nature out with a pitchfork, she will still find her way back." p. 40.

". . . when they say that for cases diagnosed as urgent or critical the waiting list, practically speaking, does not exist. This is far from disproving the function and necessity of the waiting list as a rationing device. For one thing, 'urgent' and even 'critical' are not objective magnitudes; on the contrary, they are assessments that have already taken the volume of supply into account. In any case, there is no clear-cut dividing line between the 'urgent' cases, seen or treated at once, and the 'non-urgent' cases on the waiting list — or, as the case may be, not on the waiting list at all. The latter are squeezed down — or off — by the former. To point to the fact no 'urgent' case goes untreated as evidence that supply and demand can be brought into balance without rationing is like arguing in a famine that because nobody dies of starvation, there need have been no rationing system." p. 41.

"The supply of medical care of all kinds through the National Health Service is rationed by forcing the potential consumer to choose between accepting the quality and quantity offered or declining the care offered. If he declines the care offered, he can either renounce or defer treatment altogether or he can endeavour to purchase it outside the National Health Service." p. 41.

"The result is to impart a unique rigidity and centralization to the conduct of the activities of something approaching half a million persons in a vast variety of institutions throughout the country. The effects are felt both in the relationship between the state and the professions and in the form the development of the service takes." p. 44.

"In the professions it promotes the sense of being subordinate, in a professional capacity, to lay control and decision. In the last resort, all final decision is lay, whether the decision be that of an individual to undergo an operation or of Parliament to institute a national health service. The principle is not limited to medicine but is universal: the professional is the servant, albeit specially endowed and equipped, while the layman (albeit often called the 'client') is the consumer who commands the service and decides whether he will take the advice or no. In all government the last word is of necessity lay, that is, non-expert: . . ." p. 44.

"The idea therefore that the professional could ever be 'on top', like that of a state health service controlled by the doctors, is a chimera." p. 45.

Additional copies of this speech reprint may be obtained from the Association of American Physicians and Surgeons, 2111 Enco Drive, Oak Brook, Illinois 60521.

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Form 190

Mr. ROSTENKOWSKI. Thank you, Dr. Ball.

At this time I would like to introduce a member of the full Committee on Ways and Means, a very valuable and competent member, Mr. Rangel.

Mr. RANGEL. Thank you, Mr. Chairman, for extending me this courtesy, even though I am a member of the full committee, I don't have the opportunity to sit on this subcommittee. I take a great deal of pleasure to present to you Dr. June Christmas, our Commissioner of Mental Health Services and Retardation in the city of New York, a person who has not only had extensive experience but has performed outstandingly in this field. But more importantly she has a compassionate understanding of the problems of the sick and aged. I think it would be very valuable to hear her testimony.

As New York State goes to its fiscal crisis, I am certain we will provide the type of legislation to make sure we protect all of our people and not just a selected few who can make it on their own.

Dr. CHRISTMAS. Thank you, Mr. Rangel.

STATEMENT OF JUNE J. CHRISTMAS, M.D.

Mr. Chairman, members of the subcommittee, I speak also as vice chairperson of the New York State Committee for National Health Security. On behalf of our committee, I would like to thank the members of the Subcommittee on Health for this opportunity to share our views on the matter of national health insurance.

Our committee was organized in June 1974, to provide information and education on the need for a unified national health program. We believe that health care is a right, not a privilege.

Our health system is in dire need of improvement. Despite the impressive skills of many physicians and medical institutions in America, we are not as healthy as people in many other industrial countries. This is due at least in part to the fact that health care is not available to all citizens; it is denied to many who live in rural areas or poor neighborhoods. Even where care is adequate and available it is too costly. Furthermore, lack of integration of all sectors of planning and providing health care has led to waste within the system.

Increasingly, there is agreement that health insurance is needed to balance the inequities in our health care system. To right the existing "wrongs" in our health system we believe that national health insurance must provide:

Universal coverage with one program covering everyone;

Comprehensive health care services with preventive care as well as diagnosis, treatment, and rehabilitation applicable to physical and mental hygiene needs alike, integrated into one health delivery system;

Administration by a Federal agency such as the Social Security Administration;

National standards for health care providers and strong quality review mechanisms;

Effective cost controls;

Consumer participation and public accountability;

Incentives to develop alternative health care delivery modes, such as HMO's and other group practice plans, through manpower support and financial, professional, and other mechanisms.

The Kennedy-Corman bill, S. 3–H.R. 21, of the major proposals before Congress, deals most effectively with these important issues. The attempt within this legislation to provide a scheme for comprehensive health care has earned the support of our committee and, hopefully, of your Subcommittee on Health.

We are not unmindful of the problems within the Kennedy-Corman bill such as the limitations on drug and dental care coverage. However, I would like to address serious limitations within this bill as they relate to mental health, mental retardation, and alcoholism coverage.

Members of the committee, if anyone suggested to you that we adopt a national health insurance scheme which provided one level of coverage for one race or religion, and a lesser level of coverage for another race or religion, you would all be horrified. And if anyone suggested to you that we adopt a national health insurance scheme which provided one level of coverage for men, and a lesser level of coverage for women, you would be equally horrified. Our awareness of the inappropriateness of such discrimination has been significantly raised over the last half century. Today, almost everyone would agree that race, or creed, or sex, should not disqualify any person from the enjoyment of full human civil rights.

Yet, if I were to tell you, then, that you are seriously considering legislative proposals today that reflect as stark and as insupportable a discrimination on another specific part of our population, you might be surprised at my assertion. But major health insurance proposals including even H.R. 21 place limitations and restrictions on persons receiving mental health services or in need of them, restrictions imposed on no other group of people.

Mental illness and mental retardation carry today, in contemporary America, much of the stigma that leprosy carried in Biblical society. We are so ashamed and frightened by the mentally ill and by the spectre of mental illness that we lock suffering people into custodial institutions and offer them the most minimal treatment alternatives when their actions strike us as too dissonant. We become so afraid of accepting and responding to behavior disorders that we often hide questions we have about our own health. We disqualify from public office those who have confronted their mental health rather than denied the need for such a confrontation. No group today is treated so medievally as the mentally ill. This subpopulation is the last in our society to be acknowledged as deserving full human and civil rights. But I say to you that the suffering of this group is enormously enhanced and its pathology unnecessarily intensified by the stigma society imposes.

I am asking you today to accord mental illness the same status as all other illnesses in national health insurance legislation. I welcome an honest and rigorous attempt to set clinical standards and to define levels of care. But let these standards be based on the individual clinical context and let them be extended to every American—whether he is suffering from appendicitis, cancer, tuberculosis, or mental illness. To allow unlimited benefits for most other classifications of illness while imposing severe arbitrary and countertherapeutic limitations on the single category of mental illness is discriminatory. If a time limitation is to be imposed for in-patient hospitailzation, let it be imposed for all kinds of sickness.

I support programmatic and fiscal controls which are designed to assure that abuses are minimized, and I would even agree that ceilings might well be necessary because our financial resources are limited. But let us at least impose these ceilings and these clinical controls upon all people whatever their particular form of illness rather than solely on the last forgotten Americans, the mentally ill and the mentally retarded.

One of the fundamental requisites of any national health insurance scheme is the guarantee of freedom of choice for patient and practitioner. In the absence of such freedom of choice, the health system created by national insurance degenerates into a rigid and choiceless bureaucracy. Two kinds of provisions are needed to insure that a meaningful choice exists for all Americans in terms of mental health care. First, comprehensive services must genuinely be available to all Americans; this is accomplished by promoting the viability of those providers who offer comprehensive ranges of community based care. Second, the legislation must not eliminate any legitimate providers from receiving specified and appropriate levels of reimbursement.

Thus, I applaud those provisions in the Kennedy-Corman bill which guarantee support for community mental health centers and for other comprehensive providers, however, all such comprehensive care providers should be treated equally if they offer the same services. But, once such comprehensive services have been protected and encouraged I cannot support the subsequent exclusion of other legitimate providers from general coverage. If such exclusions were suggested in any health area other than mental health, the uproar would be deafening. Imagine a provision which protected comprehensive medical providers that offered community based endocrinological care but which provision prohibited reimbursement for services provided by individual endocrinologists. In the area of mental health there is nothing inconsistent with both protecting the viability and value of the comprehensive community facility and at the same time, under specific guidelines, with reimbursing legitimate services rendered outside the orbit of these providers.

In-patient psychiatric hospitalization for more than a brief period is, in my opinion, desirable only when less drastic treatment settings are unworkable or unavailable. The in-patient solution—which necessarily segregates the patient from on-going contact with the outside world—should be employed sparingly. But the appropriateness of in-patient psychiatric hospitalization should be determined by clinical factors, and not by arbitrary ceilings on lengths of stay which are uniquely imposed on psychiatric services. If the legislature is to decide that no one should be covered for more than 45 in-patient days during any one benefit period, let this standard be applied evenhandedly to all the ill and not just to the psychiatrically needy.

The senselessness and cruelty inherent in an automatic cutoff of financial benefits in one targeted health area, even if the services are clinically essential, is self-evident. I am entirely in favor of effective and hardnosed clinical standard setting, program evaluation, and peer review. But such thoughtful treatment criteria should not be substituted for by arbitrary limitations which are applied regardless of clinical realities. I therefore suggest that guidelines be established through which it can be determined whether in-patient phychiatric hospitalization is indeed the appropriate treatment solution—but that once such hospitalization is indicated, that the same yardsticks in terms of ceilings on lengths of stay and reimbursement levels be accorded to mental health services as to all other health services.

It is ironic that the most comprehensive national health insurance proposal, the Kennedy-Corman bill, while recognizing the programmatic and fiscal disadvantages of in-patient psychiatric hospitalization, makes this the only practical solution because those proposals refuse to significantly reimburse alternative treatment modalities. If we do not want to keep a patient in a closed mental hospital setting, we cannot expect to facilitate his recovery by refusing to pay for his outpatient care, or for his rehabilitative services, or requiring that they be provided by a single type of provider.

As far as outpatient services for mental health are concerned, the same standards should be employed as for any other outpatient health care. The Kennedy-Corman proposal for national health insurance allow unlimited visits to physicians other than psychiatrists—whether the patient is terminally ill, marginally uncomfortable, or a chronic hypochondriac. Yet when mental health care is considered, even if it is entirely mandated by clinical indicators, it is limited to relatively few visits, and even these visits often must be at a favored facility or offered by a particular category of provider. Again I ask that the same rights be extended to those seeking mental health care as those seeking relief from heart disease, allergies, or exema. If a decision is to be made that an individual is entitled to only some ceiling of coverage such as a fixed number of visits, let that standard be applied indiscriminately in all health contexts. But, if a ceiling on mental health visits must be imposed, in spite of the lack of such ceilings for other fields of medicine, let it at least be realistic clinically so that the treatment makes sense.

Until parallelism for all disabilities within a health coverage is reflected in legislation, a relegation of mental illness and mental retardation will continue to compound the difficulty of patients, and will perpetuate a stigma which is not in the national interest. Thus, while H.R. 21 is welcomed in that it begins to strip away some of the discriminations imposed on mental disability and the mentally disabled patient, the ultimate aim of this committee should be the passage of comprehensive health insurance legislation with no second class disabilities or second class patients.

Thank you.

[The prepared statement follows:]

STATEMENT OF JUNE J. CHRISTMAS, M.D., NEW YORK STATE COMMITTEE FOR NATIONAL HEALTH SECURITY

I am Dr. June Jackson Christmas, Commissioner of the Department of Mental Health and Mental Retardation Services of the City of New York. I am also a Vice-chairman of the New York State Committee for National Health Security.

On behalf of our Committee I would like to thank the members of the Subcommittee on Health for this opportunity to share our views on the matter of National Health Insurance.

Our Committee was organized in June 1974 to provide information and education on the need for a unified national health program. We believe that health care is a right, not a privilege.

Our health system is in dire need of improvement. Despite the impressive skills of many physicians and medical institutions in America, we are not as healthy as people in many other industrial countries. This is due at least in part to the fact that health is not available to all citizens; it is denied to many who live in rural areas or poor neighborhoods. Even where care is adequate and available it is too costly. Furthermore, lack of integration of all sectors of planning and providing health care has led to waste within the system.

Increasingly, there is agreement that health insurance is needed to balance the inequities in our health care system. To right the existing "wrongs" in our health system we believe that national health insurance must provide:

Universal coverage with one program covering everyone;

Comprehensive health care services with preventive care as well as diagnosis, treatment and rehabilitation applicable to physical and mental hygiene needs alike, integrated into one health delivery system;

Administration by a federal agency such as the Social Security Administration;

National standards for health care providers and strong quality review mechanisms;

Effective cost controls;

Consumer participation and public accountability;

Incentives to develop alternative health care delivery modes, such as HMOs and other group practice plans, through manpower support and financial, professional and other mechanisms.

The Kennedy-Corman bill, S. 3, H.R. 21, of the major proposals before Congress, deals most effectively with these important issues. The attempt within this legislation to provide a scheme for comprehensive health care has earned the support of our Committee and hopefully, of your Subcommittee on Health.

We are not unmindful of the problems within the Kennedy-Corman Bill such as the limitations on drug and dental care coverage. However, I would like to address serious limitations within this bill as they relate to mental health, mental retardation and alcoholism coverage.

Members of the Committee, if anyone suggested to you that we adopt a national health insurance scheme which provided one level of coverage for one race or religion, and a lesser level of coverage for another race or religion, you would all be horrified. And if anyone suggested to you that we adopt a national health insurance scheme which provided one level of coverage for men, and a lesser level of coverage for women, you would be equally horrified. Our awareness of the inappropriateness of such discrimination has been significantly raised over the last half century. Almost everyone would agree that race, or creed, or sex, should not disqualify any person from the enjoyment of full human civil rights.

If I were to tell you, then, that you are seriously considering legislative proposals today that reflect as stark and as insupportable a discrimination on another specific part of our population, you might be surprised at my assertion. If I were to state, even beyond that assertion, that this discrimination is so ingrained and accepted that it is usually left unquestioned, you might be even more surprised. But we have seen prominent national spokesmen from both our major political parties sponsor rival national health insurance proposals which would maintain the mentally ill and the mentally retarded in a position of shame and neglect—a uniquely debased position which is forced on no other subpopulation and which should evoke our gravest concern.

Mental illness and mental retardation carry today, in contemporary America, much of the stigma that leprosy carried in biblical society. We are so ashamed and frightened by the mentally ill and by the spectre of mental illness that we lock suffering people into custodial institutions and offer them the most minimal treatment alternatives when their actions strike us as too dissonant. We become so afraid of accepting and responding to behavior disorders that we often hide questions we have about our own health. We disqualify from public office those who have confronted their mental health rather than denied the need for such a confrontation. No group today is treated so medievally as the mentally ill. This subpopulation is the last in our society to be acknowledged as deserving full human and civil rights. The suffering of this group is enormously enhanced and its pathology unnecessarily intensified by the stigma society imposes.

The limitations and restrictions placed on persons receiving mental health treatment are unique in that they are imposed on no other group of Americans in need of treatment. The cost in terms of human productivity—both emotionally and materially—that results from this kind of discrimination is staggering.

People who might well become productive are allowed to languish in psychic isolation, and the expense to society in the long run is far greater than any short or intermediate range treatment costs would be. Furthermore, this attitude of discrimination hurts not only the visibly mentally ill and retarded: it also hurts every one of us. It establishes a social and political climate in which the individual is discouraged from exploration and in which society projects such animosity on those who show external signs of mental stress that the average citizen feels the need to deny the normal pressures he feels.

Because mental illness involves an entire range of suffering that has both physical and nonphysical components, it is not as neatly locatable and curable as some purely physiological syndromes. Ironically, this fact, rather than challenging us to summon greater resources and greater ranges of discipline into the search for answers, has produced the precisely opposite reaction. Practitioners of mental health are criticized because their subject matter is so much more inclusive and because the answers are often more multi-dimensional. Consequently, mental health treatment alternatives are hindered by a lack of adequate public support and understanding.

What I am asking you today is to accord mental illness the same status as all other illnesses in national health insurance legislation. I welcome an honest and rigorous attempt to set clinical standards and to define levels of care. But let these standards be based on the individual clinical context and let them be extended to every American—whether he is suffering from appendicitis, cancer, tuberculosis or mental illness. To allow unlimited benefits for most other classifications of illness while imposing severe arbitrary and countertherapeutic limitations on the single category of mental illness is discriminatory. If a time limitation is to be imposed for inpatient hospitalization, let it be imposed for all kinds of sickness. I support programmatic and fiscal controls which are designed to assure that abuses are minimized, and I would even agree that ceilings might well be necessary because our resources are limited. But let us at least impose these ceilings and these clinical controls upon all people whatever their particular form of illness rather than solely on the last forgotten Americans, the mentally ill and the mentally retarded.

As you all know, one of the fundamental requisites of any national health insurance scheme is the guarantee of freedom of choice for patient and practitioner. In the absence of such freedom of choice, the health system created by national insurance degenerates into a rigid and choiceless bureaucracy. Two kinds of provisions are needed to insure that a meaningful choice exists for all Americans in terms of mental health care. First, comprehensive services must genuinely be available to all Americans; this is accomplished by promoting the viability of those providers who offer comprehensive ranges of community based care. Second, the legislation must not eliminate any legitimate providers from receiving specified and appropriate levels of reimbursement.

Thus I applaud those provisions in the Kennedy-Corman bill which guarantee support for community mental health centers and for other comprehensive providers, although all such comprehensive care providers should be treated equally if they offer the same services. But, once such comprehensive services have been protected and encouraged, I cannot support the subsequent exclusion of other legitimate providers from general coverage. If such exclusions were suggested in any health area other than mental health, the uproar would be deafening. Imagine a provision which protected comprehensive medical providers that offered community based endocrinological care but which provision prohibited reimbursement for services provided by individual endocrinologists. In the area of mental health there is nothing inconsistent with both protecting the viability and value of the comprehensive community facility and at the same time, under different specific guidelines, with reimbursing legitimate services rendered outside the orbit of these providers.

Inpatient psychiatric hospitalization for more than a brief period is, in my opinion, desirable only when less drastic treatment settings are unworkable or unavailable. The inpatient solution—which necessarily segregates the patient from ongoing contact with the outside world—should be employed sparingly. But the appropriateness of inpatient psychiatric hospitalization should be determined by clinical factors, and not by arbitrary ceilings on lengths of stay which are uniquely imposed on psychiatric services. If the legislature is to decide that no one should be covered for more than forty-five inpatient days during any one benefit period, let this standard be applied evenhandedly to all the ill and not just to the psychiatrically needy.

The senselessness and cruelty inherent in an automatic cutoff of financial benefits in one targeted health area, even if the services are clinically essential, is self-evident. I am entirely in favor of effective and hardnosed clinical standard setting, evaluation, and review. But such thoughtful treatment criteria should not be substituted for by arbitrary limitations which are applied regardless of clinical realities. I therefore suggest that guidelines be established through which it can be determined whether inpatient psychiatric hospitalization is indeed the appropriate treatment solution—but that once such hospitalization is indicated, that the same yardsticks in terms of ceilings on lengths of stay and reimbursement levels be accorded to mental health services as to all other health services.

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As far as outpatient services for mental health are concerned, the same standards should be employed as for any other outpatient health care. The Kennedy-Corman proposal for national health insurance allows unlimited visits to physicians other than psychiatrists—whether the patient is terminally ill, marginally uncomfortable, or a chronic hypochondriac. Yet when mental health care is considered, even if it is entirely mandated by clinical indicators, it is limited to relatively few visits, and even these visits often must be at a favored facility or offered by a particular category of provider. Again I ask that the same rights be extended to those seeking mental health care as those seeking relief from heart disease, the sniffles, or headaches, real or imagined. If a decision is to be made that an individual is entitled to only some ceiling of coverage such as a fixed number of visits, let that standard be applied indiscriminately in all health contexts. But, if a ceiling on mental health visits must be imposed, in spite of the lack of such ceilings for other fields of medicine, let it at least be realistic clinically so that the treatment makes sense.

Until parallelism for all disabilities within a health coverage is reflected in legislation, a relegation of mental illness and mental retardation will continue to compound the difficulty of patients, and will perpetuate a stigma which is not in the national interest. Thus while S. 3 is welcome in that it begins to strip away some of the discriminations imposed on mental disability and the mentally disabled patient, the ultimate aim of this committee should be the passage of comprehensive health insurance legislation with no second class disabilities or second class patients.

Mr. ROSTENKOWSKI. Thank you, Dr. Christmas.

Mr. Samuel.

STATEMENT OF HOWARD D. SAMUEL

Mr. SAMUEL. Mr. Chairman, my name is Howard D. Samuel. I speak here in two capacities, Secretary of the New York State Committee for National Health Security but perhaps more meaningfully as vice president of the Amalgamated Clothing Workers of America. I think the chairman is acquainted with some of our members and leadership in this area. I submitted a statement and I am not going to follow it, if I may, but proceed in a summary fashion.

Mr. ROSTENKOWSKI. Your statement will be placed in the record.

Mr. SAMUEL. Let me give a quick summary of the nature of our committee. The New York State Committee for National Health Security is an affiliate of the National Committee for National Health Security. We have our own officers, New Yorkers. They represent the labor and business community, churches, various other kinds of community groups, minority groups in civil rights, and so forth. I have a copy of the letterhead of the committee, of our committee, to be submitted to this subcommittee if you would like the names of the people who are associated with us.

Let me take a moment, if I may, to describe a couple of experiences I have had recently which may be of interest to you because I have heard earlier today members of the subcommittee refer to some polls which showed that most people in this country seem not to be terribly concerned about health care. That is not my experience.

Last night I was in Troy, N.Y., which is one kind of community, and last week in El Paso, Tex. We have members of our union in each of those communities. I asked our members what are the kinds of interests that bother you, concern you, and trouble you in your lives?

In both cases, in El Paso, which is removed culturally, economically, and politically from Troy, N.Y., the issue was health care. This is the issue that bothered them most. They see it as a personal issue, but even more than that it is an issue which bothers their families and their communities. For these people the present system of health care has not solved the problem of health costs.

Their costs are too great for working people to bear. I might add this is not only a problem for them, but the union that represents them.

The Amalgamated about 6 months ago had to come to our members and ask that a wage increase, which had been contracted for, be instead diverted for 4 months. That wage increase was diverted instead to our health insurance program so that it would not go bankrupt.

Now, why would our health insurance program be close to bankruptcy at that time? Two reasons: One was the recession and unemployment. The other was the climbing, astronomical costs of health care to the point where our health insurance director has stated, and he is a health man, not a labor man, that the present cost and mode of cost indemnity for sickness and accident simply can't be maintained.

The costs are so high that no union fund can possibly subsidize this system in the years ahead as the costs rise higher. The costs of medical care are not only too much of a burden for workers to carry, but, of course, the same kinds of costs are a similar burden on companies.

The companies in our industry are having to pay more and more to cover the same insurance programs that they used to pay for for much less, and the same burden that our members have to carry is also being borne by the business community.

It goes beyond that. Those same rising costs are being borne by cities. Since I come here from New York, let me point out that New York, which is much in our minds and the minds of Congress, more than 20 percent of the city budget is for health care, including mandated costs such as the city's share of medicaid. A report shows that had we had legislation in effect applying the Kennedy-Corman bill, that for the just concluded fiscal year, 1974–75, there would have been a reduced burden between $407 million and $433 million to the city of New York in running its public hospital system.

Another study prepared by Jeffrey Weiss, director of planning, Downstate Medical Center, confirms the above. His study, which covered all tax levy funding for health, included all cost for other health care services and supports for the voluntary sector, estimated a reduced financial burden for the same fiscal year, 1974–75, of $895 million. This figure, I am informed, is greater than the budget deficit for the year. In other words, New York's problems could have been solved.

You wouldn't be faced with the problems facing New York City if the Kennedy-Corman bill had been passed.

My testimony indicates also Orange County, a suburban and rural county, faces the same kinds of problems caused by the rising costs of medical care. Let me go back to El Paso and Troy.

Was it only costs? Another factor was a lack of adequate care. The fact is that in Troy particularly—and it is also a problem in El Paso—there is a lack of doctors. We hear about the lack of doctors in rural areas. The fact is Troy is not a rural area. The fact is it is a poor community.

Doctors are not able to find the kind of income they desire and are not there in adequate numbers. As far as our members perceive the situation, they find they can't get adequate medical care and a newcomer has difficulty in finding a doctor to accept a new family as a patient on a regular basis.

I might add, since I have the privilege of commenting on previous testimony by Dr. Ball—I think the medical profession ought to be aware of the fact—this subcommittee also—that there is a gulf growing between the medical profession and the working people they are supposed to serve. The working people in our area, and I am sure it is true in others, are beginning to have a low opinion of the medical profession.

There is despair that the medical community is not serving the community the way it should be. When doctors, of all the groups of our community, have had their incomes rise higher than any single group in the community in the last few years, higher and far faster than the cost of living, you might want to call doctors "poor," but certainly that would not apply in terms of their incomes.

Finally, how are the costs to be paid? I understand and you understand that medical care in this country this year is going to cost something like $110 billion. The question is not how much will it cost, but who will pay for it?

I want to suggest to the members of this subcommittee, who also serve as members of the full committee of the Ways and Means that deals with tax matters, and you are now considering a tax bill, I want to tell the members of this subcommittee that if you were to devise a tax bill which provided for a tax system as regressive as the way we provide for medical care, you would not survive in office.

Working people pay for far more medical care out of their share of income than wealthy people, and that isn't right. They get less care. How is it going to be changed?

We support the Kennedy-Corman bill. We think this introduces an element of progressiveness. If this is going to be paid for, it should be done on a progressive basis. It also adds one other factor, cost controls.

There must be some way we can end this spiral upward which is fast driving our present system into bankruptcy.

Thank you.

[The prepared statement follows:]

STATEMENT OF HOWARD D. SAMUEL, VICE PRESIDENT OF AMALGAMATED CLOTHING WORKERS OF AMERICA; AND SECRETARY OF THE NEW YORK STATE COMMITTEE FOR NATIONAL HEALTH SECURITY

I appear on behalf of the New York State Committee for National Health Security in support of the Kennedy-Corman Bill, S. 3–H.R. 21.

I am Vice-President of the Amalgamated Clothing Workers of America and Secretary for the New York State Committee for National Health Security. It was organized by a group of prominent residents and leaders in our State. They are from the fields of health, religion, labor, government, academia and organized senior citizens.

Traditionally, each group in our society has attempted to solve the mounting problems of cost and availability of health care for themselves. Medicare and Medicaid was a major effort to protect the aged and the poor. Organized labor and industry, through collective bargaining, provided health plans for its members and their families.

Medicare, with rising cost and lack of controls, has been providing a smaller share of health cost of the elderly each year. Organized labor has been forced to divert needed dollars from the pay envelope to the increased health care premium. Our own union recently had to amend a previously signed contract in order to assure solvency of the Funds providing for health care of our members. Industry, especially the relatively low paid apparel industry, has demonstrated that they can no longer absorb the increased cost of health care provided for its workers.

It is therefore not surprising that organized senior citizens groups and labor have been most active in the more than a dozen local coalitions throughout New York State working for the Kennedy-Corman Bill.

Government leaders including Governor Hugh Carey and Mayor Abraham Beame and heads of major cities and counties have supported our efforts.

More than half of all personal bankruptcies are caused by the burden of health care cost. We support the Kennedy-Corman Bill because it relieves everyone of the cost of health care, from preventive care through major illnesses.

Our committee is strongly opposed to the Long-Ribicoff Catastrophic Illness proposal. In New York the average daily hospital cost is $155, and charges in excess of $200.00 per day are not uncommon. Therefore the patient obligation would be, on average, for the first 60 days, $9300.00, and could easily exceed $12,000.00. When we then add, for physician services, the $2000.00 deductable and the co-insurance features of this legislation, we, indeed, have a truly catastrophic situation. Most people would already be bankrupt before they become eligible. It would do little to help many who now file for personal bankruptcy due to health cost. There would be little effort to control cost or improve services. One could expect that there might be a tendency to inflate cost and extend services to comply with the expensive prerequisites. And the majority who could never be eligible would have to pay for it. We're better off without it.

The fiscal crisis in New York has been aggravated by rising unemployment and inflation. Health care cost for services provided by the City and an increase in the number of persons needing these services has been an important factor in this situation. More than 20 percent of the City budget is for health care, including mandated cost such as the City's share of Medicaid.

A report by the Health and Hospital Corporation of New York City, which runs our municipal hospital system, shows that had we had legislation in effect like the Kennedy-Corman Bill, S. 3–H.R. 21, that for the just concluded fiscal year 1974–75, there would have been a reduced burden of between $407 million and $433 million dollars.

A study prepared by Professor Jeffrey S. Weiss, Director of Planning at Downstate Medical Center for a task force of the New York Metropolitan Regional Medical Program confirms the above. His study which covered all city tax levy funding for health, included cost for other health care services and supports for the voluntary sector, estimated a reduced financial burden for the same fiscal year, 1974–75, of $895 million dollars. This figure, we are informed, is greater than the budget deficit for that year.

This is not just a problem for New York City. It now appears that our State and local governments are unable to keep up with this burden. Almost two-thirds of the New York State welfare budget is for Medicaid. This year Orange County, a suburban and rural area, was unable to provide its share of a 5½ million dollar deficit in its welfare cost. Their Medicaid cost exceeded the deficit.

While health care places an ever rising burden of cost on the individual and on government we see little improvement in the delivery of health care.

We, in organized labor continue to support the need to provide health care for the unemployed. However, we are not unmindful of the inequities and highly inflated cost of such programs.

Only by passage of legislation like S. 3–H.R. 21 will we begin to provide comprehensive health care for all with meaningful cost and quality controls.

We thank you for this opportunity to share our views.

Mr. ROSTENKOWSKI. Thank you.

Mr. Stevens?

STATEMENT OF ROY STEVENS

Mr. STEVENS. The New England Committee for National Health Security is grateful for the opportunity to offer testimony on the important issue of national health insurance. Our organization is a coalition of groups concerned with health care in the United States. It is made up of thousands of consumers and providers from organized labor, senior citizens, women's, church, civic, business, academic and health professionals' organizations throughout New England.

The American people are in desperate need of a comprehensive national health insurance program. This need is most evident in the New England region where we are enduring the terrible effects of high unemployment, an even higher rate of inflation, and the absence of a national energy program. These economic problems have raised havoc with the shrinking budget of the average New England family.

The situation has been made worse by the constantly increasing cost of medical care. The threat of spending down one's income below the poverty level has become a greater likelihood as the cost of health insurance premiums, deductibles, coinsurance payments, and out-of-pocket costs have risen.

As regional director of a union that prides itself on the health benefits it has won for its members through collective bargaining, I am well aware of the inadequacies of health insurance provided by the private sector.

The Blue Cross in Massachusetts has practically used up their reserves; the Blue Shield, the doctors' organization in Massachusetts, in the past has done a pretty good job in keeping down the cost of operations performed in hospitals. The subscribing doctors and almost every doctor in Massachusetts who is a member of Blue Shield has agreed beforehand to accept the fee established in Massachusetts as full payment for his services, but now there is an attempt being made among the doctors in Blue Shield to see to it that the Blue Shield fee is paid for nonparticipating doctors.

Now this provides an incentive for a doctor in Massachusetts not to become a member of Blue Shield so he can obtain the fee in the Blue Sheild schedule and charge his patient whatever extra he is able to get from him. This is a condition in the State of Michigan and as a result of this policy now being pursued in Massachusetts some of the members of our union have had their wages garnisheed and have been harassed by private collection agencies.

The members of our union are in no position when the members of their families are sick to bargain effectively with a doctor as to how much extra should be paid for the services that are needed by his family. In spite of the good services available, they are still not free from the costs of health not covered by policies.

It is these costs that undermine the purchasing power of their payments. A good friend of mine was going to come down here to attend to some other matters involving our union, but couldn't come because he has an appointment in court.

Mr. Jerry Collins in the city of Worcester buried his wife here a few months ago after an illness of 8 years. Because of the debts left to Mr. Collins because the medical expenses of this are so great, there is no solution for him other than to go into bankruptcy.

This is a common occurrence among the people in New England that are serviced in massive medical expenses. They look to their Government certainly for some relief from this unfairness.

All of us are spending a great deal of money for health benefits. As you are aware, the average American worker spends over 4 weeks' salary annually for health care. Organized labor will continue to seek adequate coverage for its members at the bargaining table. But other Americans are not so lucky.

There are people not represented by unions, people who work for themselves. In my own household I have a son-in-law who is an extremely competent cabinetmaker. He is trying to establish himself as an independent entrepreneur. He has no income. The cost of an individual policy is more than he can afford now and more than he can afford for many years to come.

The answer is not private insurance. We have to have some Government subsidies in these areas in order that other people don't face bankruptcy when they are afflicted through no fault of their own.

Our union has joined with the New England Committee for National Health Insurance in order that we get some fairness into the financing of health care. The control of doctors and the control of hospitals is another matter. Certainly they should have some examination made of them to see that they are prudent in the handling of the money and that there are not unnecessary operations performed by people in the medical profession, unnecessary calls made, and so forth.

We are not trying to dictate the type of medical services that shall be rendered or interfere with their lives. The question so far as I am concerned and the National Health Committee is concerned, as I understand our objectives, is to see that the great financial burden on the sick is removed from their back and is taken up by us as citizens of this country.

We are not only concerned with the financing, but it is a principal concern. We are concerned, too, with the lack of providers and the facilities that exist in the urban and rural areas of New England. We think that the existing health service system does not provide incentives that would be needed to solve this problem.

We also find fault for the existing system from excluding the public from making decisions as to how our health money shall be spent and how these services shall be provided. The New England Committee for National Health urges Congress to establish a program for national health that guarantees the right of citizens to adequate health care.

In the interest of time, I will now list what we consider to be crucial elements in the design of a national health insurance program.

One: Equity in financing. Those who have least should bear the least burden of financing, ideally, through progressive Federal income tax revenues.

We have a practical alternative. We believe 50 percent of the cost of health services could come from the general revenue, 50 percent from employer-employee contributions and make self-employed assessments. We think, however, there should be a ceiling on the annual cost imposed upon employees and that would be a $200 maximum, and we think the bill should provide that employees through their unions should be able to have this amount of money paid for by the employer as a result of bargaining on this particular issue. It would be a form of a deferred wage.

Two: Comprehensive coverage for all Americans. Whatever their age, income level, or living place, as a right bestowed by an affluent society, a right made real by most other advanced nations.

We believe H.R. 21, the Health Security Act, the proposed legislation before this committee, is the bill that most nearly meets the needs of the people that we represent in New England.

Thank you, Mr. Chairman.

[The prepared statement follows:]

STATEMENT OF ROY STEVENS, NEW ENGLAND COMMITTEE FOR NATIONAL HEALTH SECURITY

The New England Committee for National Health Security is grateful for the opportunity to offer testimony on the important issue of national health insurance. Our organization is a coalition of groups concerned with health care in the United States. It is made up of thousands of consumers and providers from organized labor, senior citizens, women's, church, civic, business, academic and health professionals' organizations throughout New England.

The American people are in desperate need of a comprehensive national health insurance program. This need is most evident in the New England region where we are enduring the terrible effects of high unemployment, an even higher rate of inflation, and the absence of a national energy program. These economic problems have raised havoc with the shrinking budget of the average New England family. And, the situation has been made worse by the constantly increasing cost of medical care. The threat of spending down one's income below the poverty level has become a greater likelihood as the cost of health insurance premiums, deductibles, coinsurance payments, and out-of-pocket costs have risen.

As regional director of a union that prides itself on the health benefits it has won for its members through collective bargaining, I am well aware of the inadequacies of health insurance protection provided by the private sector are safe from the nickel and dime expenses they must pay for health services not covered by their insurance policies. And it is these costs—not the fantastic costs of serious and chronic illness—that undermine the purchasing power of their paychecks.

All of us are spending too much money for the health benefits we receive. As you are aware, the average American worker spends over four weeks salary annually for health care. Organized labor will continue to seek adequate coverage for its members at the bargaining table. But other Americans are not so lucky. Many concerned citizens throughout New England realized several years ago the need for substantial reform of the health care system. That is why they joined together to form the New England Committee for National Health Security. And, the number of people identified with that committee increases each day.

While the cost of health care is a major concern to us, it is not the only one. It is ironic that those of us who can afford to pay for health care are often unable to obtain it. Shortages of providers and facilities exist both in urban and rural areas of New England. We blame the existing health care system for not providing the incentives needed to solve this problem.

We also find fault with the existing system for excluding the consumer from the decisionmaking process which shapes the health services we receive. Nothing alienates people more effectively than their not having a voice in the system they support financially. It is this kind of alienation that ultimately leads to confrontation that in the end works against effective reforms.

New Englanders are famous for their Yankee ingenuity and shrewdness. Today, our nation is celebrating the fruits of our efforts 200 years ago. Now, in this Bicentennial year, the people of New England are willing to lead another struggle for independence. 200 years ago, as a young nation, we struggled against "taxation without representation". How ironic it is, therefore, that the American consumer cries out against "taxation for health care without representation".

The New England Committee for National Health Security urges this Congress to enact a program of national health insurance that guarantees health care as a right for all Americans. In the interests of time, I will now list what we consider to be crucial elements in the design of a national health insurance program.

1. *Equity in financing.* Those who have least should bear the least burden of financing, ideally, through progressive Federal income tax revenues.
2. *Comprehensive coverage for all Americans,* whatever their age, income level, or living place, as a right bestowed by an affluent society, a right made real by most other advanced nations.
3. *Assurance of individual privacy and dignity to consumers.*
4. *Rapid development of services most needed by most people most of the time.* That is, we need community-based, ambulatory, and in-home services, all of which can be more personalized, less costly, and more attuned and adaptive to particular family and community needs for health services, in contrast to inpatient institutions.
5. *Access to necessary health services, beyond financing, regardless of geographic living place.*
6. *Effective access to the decisionmaking which shapes the health services by all groups affected.*
7. *National health policy machinery empowered to carry out a legislative mandate for equitable and effective health care in the United States.*

Of the proposed legislation before this Committee, the bill which most nearly meets these criteria is H.R. 21, the Health Security Act.

Mr. Rostenkowski. Mr. Simone.

STATEMENT OF EDWARD C. SIMONE

Mr. Simone. Thank you, Mr. Chairman and members of the committee.

I am here representing the Massachusetts Committee for National Health Security, a grassroots organization having the support of a large number of people of all ages from all walks of life in our State. Among our members are Mr. Frank Manning, president of the Legislative Council of the Massachusetts Association of Older Americans. Robert Ebert, M.D., dean, Harvard Medical School, Joseph A. Sullivan, president of the Massachusetts State Labor Council, and Ms. Dorothy Garrison, director of Family and Community Services, ABCD in Boston. The message I bring is one of deep concern—concern over the ever-increasing demands made upon the consumer's pocketbook by a wasteful and inefficient health care system. How much more can we bear?

At present the American worker is paying for medical care indirectly through private health insurance premiums as well as State and Federal taxes. In addition, he or she bears the direct burden of paying for health care through deductibles, coinsurance, and out-of-pocket costs.

The Massachusetts committee is opposed to the perpetuation of this system as is proposed by all but one of the national health insurance plans before this Congress. We are most vehemently opposed to a "catastrophic" solution directed solely to protecting the consumer from the financial ruin of serious illness.

While we commend Senators Long and Ribicoff for their concern over what is a major problem to a small percentage of Americans, we do not support free-standing catastrophic insurance. We criticize their proposal for doing nothing to aid the middle- and low-income wage earner who finds the cost of minor illness more burdensome each day. What good is the knowledge that if he or she should fall within the less than 1 percent of the population that becomes seriously ill, that "catastrophic" coverage will pick up the tab after personal expenditures reach $8,000 or more?

How do you explain the merits of a "catastrophic" program to a father and mother of two children who must constantly make economic sacrifices to obtain medical care not covered by their private health insurance plan? The issue, as far as we are concerned, is when an adequate health insurance plan like health security will be enacted.

It appears to be fashionable in the Nation's Capital to talk philosophically about a "good" health insurance program like health security, and then move toward seeking the cheapest program possible. Any intelligent consumer will tell you that you get what you pay for. And in our estimation a free-standing catastrophic program is shoddy goods.

It appears incredible to those of us in Massachusetts who closely follow the health insurance issue that Congress refuses to give the American people what they want—a health security program. In our State the entire congressional delegation is coming to the realization that we cannot afford to not have a comprehensive national health insurance program.

As Congressman Gerald Studds, who polled his constituents before the last election, if his district is not ready for national health security. Or ask Congressman Joseph Early about the national health insurance poll he just took in his district. Or, for that matter, check the national surveys that have been done on NHI in the past year. All will tell you, ladies and gentlemen, what many of you don't seem to understand: the majority of the people in this Nation want health security now.

We in Massachusetts regard ourselves as a bellwether for the United States. We demonstrated this 4 years ago when we stood alone in voting our conscience, and time proved us right. The day is fast arriving when national health insurance will be a major campaign issue throughout the Nation, as it is this year in Massachusetts.

Let us hope at that time all of you will be able to account for your past actions appropriately.

Thank you very much.

Mr. Rostenkowski. Is there any comments that you would like to make? Would any witness like to ask questions of another witness?

If not, Mr. Duncan will inquire.

Mr. Duncan. Thank you, I have no questions.

Mr. Rostenkowski. Mr. Waggonner will inquire.

Mr. Waggonner. Mr. Chairman, first of all, I want to say welcome to my old Navy colleague, Dr. F. M. Ball, who is here from South Carolina, and does in his statement represent that this is the first opportunity that we have had to see each other since that point in time when we were aboard the same ship.

Mac, if I can comment on the old adage about hair, you and I appear to prove it to be true. It either turns gray or turns loose. I am happy to see you here, Mac.

I just have two or three comments. Dr. Ball and I carry on something in the way of a running correspondence feud on occasion about certain aspects of medical care, doctors, their distribution, that sort of thing, all on a good friendly basis, but we do understand each other.

Mr. Simone, I recall you made a statement that Congress refuses to yield to the public what they want. Now did you mean that literally that Congress is supposed to give medical care without any charge to anybody or did you just not think that through?

Mr. SIMONE. No, Congressman. While I think we see things from a different perspective, I in New England and you in Washington, I believe our concerns are very similar. I think that the issue is access to medical care, and I am not talking about the poor who, I think, someone said earlier are getting the care.

I am concerned about the middle-income worker who is paying most of the costs of health care. I am a young man with a family who has to buy his own insurance, and I will tell you this, my bills are astronomical. And they are the same for many other Americans who can't understand they must pay so much for the health care.

I see no logic to saving money to prepare for that impending day of medical illness, particularly with the cost of everything skyrocketing and with most Americans trying to get by on what they are earning.

Mr. WAGGONNER. Let's not fall into the same trap that Senator Jacob Javits did in talking about the people of New York City when he made the foolish statement that half the people in the city of New York were below the median as far as income was concerned. That is what a median is. Half above and half below.

Who are you talking about?

Mr. SIMONE. I think any man that has a family or women—not to exclude the other sex.

Mr. WAGGONNER. You might get in trouble if you do.

Mr. SIMONE. Possibly so. I would say up to the income of $25,000.

Mr. WAGGONNER. What is the magic of $25,000? Isn't that well above the average?

Mr. SIMONE. I think statistically after $25,000 we get into the small percentage of people in this Nation. I am talking about the larger position that pays most of the taxes for the income transfer programs in Washington, like welfare, health bills, food stamps, and so forth; the taxes, in other words.

Mr. WAGGONNER. One other question.

Do you subscribe to a statement made by two or three other members of the panel recommending equity in financing that those who make the least should pay the least, which is the same, from my point of view, that everybody ought to pay to the extent they can?

Mr. SIMONE. We seem to arrive at a social problem. The ramifications of which are tremendous.

Mr. WAGGONNER. I though we were talking about a medical problem.

Mr. SIMONE. It is all interchangeable. The point is, when you get into lesser and lesser income, it becomes a matter of doing without.

Mr. WAGGONNER. Nobody is supposed to make a sacrifice?

Mr. Simone. I am not suggesting avoiding some economic choices to keep within one's budget, but I am saying if one's health is not taken care of, there will be serious ramifications. For example, a father that is sick and can't work is a problem for the Government because he cannot support his family, and in the end the Government is going to have to pick up that responsibility.

If a mother is sick, and a child is deprived of parental guidance, I think the ramifications are great. Certainly I think people should make sacrifices, but let's gear those sacrifices proportionately to the income of each and every citizen in this country.

Mr. Waggonner. Mr. Samuel, you made a statement and people commented on it in a little bit of a different way. You made a statement that you recognized that in financing health care, that costs of this care had exceeded the ability of the unions to pay for the beneficiary and not only was this so with regard to the employee, but it had exceeded the capability of management to provide for it, too.

Now, that is to say to me management can't pay for it and the employee can't pay for it. Would you explain to me how we are going to pay for these additional benefits when the employee is not making the money to pay for them? Where is tax dollars going to come from and how will you get more dollars to pay for this health care you advocate——

Mr. Samuel. I think the problem is one of spreading the costs just as you do with taxes, arranging for payment through the U.S. Government.

The fact is that I can only tell you what has been happening in our industry, which is the largest manufacturing industry in the country. That industry employs almost 2.5 million people. The fact is in the U.S. sector costs go higher and higher. For cost of care, they are going above the mark, just for health care, not potential.

Presumably if the cost could be spread out over the whole country as our tax burden is, they would pay a normal income tax and not a flat fee of 5 percent. We would like not to have more unemployment, but I think this is a more rational way of doing it and to provide better health care and, of course, the other point, why we support H.R. 21, it would also possibly exercise some control over these rising costs which are so difficult for us to support.

Mr. Rostenkowski. Mr. Cotter will inquire.

Mr. Cotter. Thank you very much.

Dr. Christmas, you have suggested that any national health insurance program would cover mental illness completely.

Dr. Christmas. Yes, sir.

Mr. Cotter. Do you have any estimated costs on this?

Dr. Christmas. We can estimate the expenditures that are currently put forth in regard to mental health services vis-a-vis the total health expenditures we talk about, total health expenditures of $104 billion. Mental health expenditures from all sources, private practitioners, public facilities, et cetera in that same time, fiscal 1974, came to $12 billion, so I would estimate any additional costs we would probably bear that same percentage, a little over 10 percent.

Mr. Cotter. Ten percent of whatever there would be over the Kennedy-Corman bill, and the estimates go from 104 to 118. Let me ask you—I seem to recall in New York their hospitals provided mental health care; is this correct?

Dr. CHRISTMAS. City hospitals do provide mental health care in New York. However, for those persons who have Blue Cross and Blue Shield with mental health coverage, that coverage is not allowable in those city institutions.

Mr. COTTER. I understand that. How about charity cases? I understand that hospital care in New York is free. Is that correct?

Dr. CHRISTMAS. No; it is not free really. Those people who can pay. pay. Those people covered under medicaid—the increasing numbers of people who are medically indigent strive to pay the bill. So all patients are billed. There is no such thing as an automatic free patient unless that person were completely unable to pay and in that case that person would be eligible for medicaid.

Mr. COTTER. Do you have a problem with bad debts?

Dr. CHRISTMAS. Yes.

Mr. COTTER. Serious?

Dr. CHRISTMAS. It has improved in the last years under the new administration.

Mr. COTTER. What percentage of hospital costs are uncovered?

Dr. CHRISTMAS. I do not have that figure before me.

Mr. COTTER. You have no estimate?

Dr. CHRISTMAS. I would be only estimating. I do know there has been a great increase in nonrecoverable costs under the new hospital administration.

Mr. COTTER. Could you provide those figures?

Dr. CHRISTMAS. Those figures are available. I don't have them on hand. I certainly could get them.

[The information appears on p. 902.]

Mr. COTTER. Could you also provide us the costs of providing mental health care in those New York hospitals?

Dr. CHRISTMAS. That I can give you now. The total cost of public health system, about $1 billion, yes, that system of 19 hospitals—about $1 billion.

Mr. COTTER. $1 billion a year?

Dr. CHRISTMAS. Yes, all kinds of services in those hospitals. The mental health budget, sir, was about $100 million or $105 million, so it was about the same proportion that I mentioned.

Mr. COTTER. Well, you know it is highly desirable and I have no quarrel with you over that, but I just don't know where the money is coming from. You take New York. Already you recited a figure of a hundred million dollars. This is one city in America.

Let's say it is equivalent to a State. To expand 50 States we are talking $5 billion probably.

Dr. CHRISTMAS. Sir, we are talking about costs which are being expended in a nonsystem with the expenses borne unevenly and I think we are suggesting that a system of national health insurance equitably financed might have much greater possibilities of providing the kind of quality care that we are talking about.

Mr. COTTER. But it has got to cost so much more. You know, we have heard testimony here that you were already spending over $100 billion a year and we are going to redistribute it, and it isn't going to cost any more. I think that is a fallacy. The Kennery-Corman bill would provide more expensive and better care than we are presently getting, which has got to, in simple mathematics, cost more.

Dr. Christmas. Exactly. I would say the expenditures that occur now might be whittled down with greater cost controls, with greater utilization review than we have now, with greater evaluation. I do not believe that in the kind of system we have now that we know enough about cost-effectiveness nor have we exerted our energies and I think this kind of effort, as built into the Kennedy-Corman bill, is one that would ultimately perhaps not lead to as great an increased expenditure as you believe.

Mr. Cotter. The problem is there are some senior Members of this Congress and this committee who can remember the estimates of medicare that the first-year costs would be $250 million. I think they ran five times over that.

There is a great timidity to add benefits and health particularly when you are faced with a $70 billion deficit. You have your own city which finds itself on the verge of bankruptcy. God only knows what is going to happen to this country if we follow the same pattern.

This is what concerns me.

Dr. Christmas. Mr. Cotter, I share those concerns. I think our example of how we handled medicaid is not a very good one to follow. I think there has to be greater accountability, greater controls than what did take place in medicaid. We know private practitioners abused it and many others abused it.

Mr. Cotter. You are right. I have been in government some 20 years and I have yet to see any level of government do things in overly efficient manner. This is what frightens me with Federal control of all health costs.

Mr. Rostenkowski. Mrs. Keys will inquire.

Mrs. Keys. Thank you, Mr. Chairman.

I think we have an adequate inquiry period. I don't intend to take up time, but I would like to comment upon the effective and efficient testimony, particularly Mr. Simone, Mr. Stevens and Mr. Samuel, in representing the problems that the people of your group and unions face in trying to receive health care.

I am very concerned that we do something about giving access to all citizens in this country. I would like to also say to Dr. Christmas I am particularly interested in your testimony today. I hope you had the opportunity of hearing Dr. Roy Meninger, who is a constituent of mine, and Margaret Meed this morning on the Today Show as they had a very fine dialog and discussion of a conference that was held in New York about a caring society.

I think some of the aspects of your testimony are inherent in our development toward that kind of total society. I am very concerned with working with the resources I have in my district to find the kind of clinical controls and effective controls that can help us include mental health in a national health insurance program.

I would like to speak with you sometime in the future, if I might.

Dr. Christmas. Thank you for those comments.

Mr. Rostenkowski. Mr. Simone, you mentioned there was a questionnaire put out.

Mr. Simone. Yes.

Mr. ROSTENKOWSKI. I was wondering, how was the question worded on the need for national health insurance?

Mr. SIMONE. Among several surveys, I would cite the recent Cambridge survey which demonstrated an extremely interesting point that 22 percent of the people in this Nation backed socialized medicine. We are not talking about a comprehensive national program, but a complete takeover. You wish to know how the question was phrased in the survey?

Mr. ROSTENKOWSKI. Yes.

Mr. SIMONE. In Congressman Studds' district it was phrased "Do you support a comprehensive program such as National Health Security"? Over 50 percent of the people in his district said "Yes".

Congressman Early asked in terms of a comprehensive national health insurance program. Of all the responses, by far the largest majority answered that question "Yes, they do." As for the Cambridge survey, I don't have a copy of the results with me, but I will be glad to submit a copy later. I believe it was reported last month in the Chicago Sun-Times.

They asked four questions which were geared toward (1) the status quo, (2) the Long-Ribicoff proposal, (3) the Chip plan (the Nixon administration plan), and to health security (4) to socialized medicine. Questions three and four were favored by 55 percent of responses.

Mr. ROSTENKOWSKI. The reason I ask that is there is a way one can frame a question that would necessarily receive an affirmative answer or a negative answer. I was just wondering if in questioning people, with your supporting NHI with a tax increase, what their response would be if you discuss it in terms of what the increase in deficit would be. What would their response be then.

I conducted surveys in my congressional district and found there is an affirmative response to the need for health insurance; but, when you talk about possible increased costs, arising from health insurance for everyone, a serious financial question arises.

But, I think in the not too distant future we are going to have a plan.

I don't know what form it will take or how far it will reach, but I do hope we find here then this testimony, that the resistance is somewhat weakening to a comprehensive program.

Mr. SIMONE. Congressman, I don't know if this is appropriate, but I would suggest that I recognize that we as a country are a very disparate group of people, and some Congressmen's districts are very conservative on the health insurance issue.

But as I travel throughout New England, into rural Maine and Vermont, and into urban Massachusetts, Rhode Island, and Connecticut, I find that the health insurance issue is a pressing one on people's minds.

It appears that only the catalyst has not been found to really generate it.

Mr. ROSTENKOWSKI, I don't find—and we discussed this yesterday—national health insurance high on recent surveys rating priorities in Government.

When you talk about priorities, you are talking about spending, inflation, and spiraling costs. National health does not appear in that priority list. I am disappointed that it does not, but it does not appear.

But, when you are asking a question directly about national health insurance, I can understand an affirmative response.

Mr. SIMONE. The reality, as I see it, is simple. Most Americans do not understand the inadequate coverage they have under the present system. Since most Americans are being bombarded by the rising cost of everything, only when they are sick does concern about health insurance become a priority. Do you eat first or care for yourself first? Unless you are sick, you are not going to put on a survey that health care is your priority. Otherwise, your stomach and your children come first.

If the present system continues, it will reach a point where few will be able to pay for health care. For example, most private policies do not cover pediatric care for children. When a worker's child is ill, he or she is faced with a dilemma: Do they take their child to a doctor or hope the illness will go away without a doctor's care.

Mr. ROSTENKOWSKI. When you enlarge the umbrella, a cost factor comes in and goes up, so there will be an increased cost in national health insurance. We are becoming very concerned with spiraling budgets. We put a budget ceiling on what we are going to spend on the House floor yesterday.

This committee is going to try in the next year to write legislation on national health insurance. But while we must dance to the tune played in our congressional districts, we are now starting to have people express concern about excessive Government spending. They want to cut Government spending. That is becoming a real issue.

Mr. SIMONE. I have my own thoughts about what the constituents are saying about Federal involvement in health care. We could debate it for hours. As I see it, all but one of the health insurance programs proposed do not offer the cost controls necessary.

I realize as do most people the dollars you spend on health care today, you are not going to cut back on tomorrow. They are still going to be in there. Ultimately, we will reach the day of—let me resort to rhetoric—Armageddon in terms of costs.

Dr. BALL. Mr. Chairman, there is no way that a Government program of health care can be any cheaper or save any money.

The same drugs have to be paid for; the same people, nurses, doctors, health care assistance has to be provided. The same hospitals have to be paid and the people that work for the hospitals. And, in addition to all of these costs, there will be the cost of an enormous bureaucracy on top of all this to work this system.

There is no way that the Government can make it any cheaper. These control programs that are talked about are already in existence. We already have utilization and review committees that cut down on hospital stays. I have in my briefcase here a report just in October from a hospital in Memphis pointing out that the tremendous increase in costs of service to the medicare patient as compared with other patients.

Just in paperwork alone, a Blue Cross-Blue Shield patient has five forms to fill out. A private insurance company's patient has seven forms to fill out. A medicare patient has 16 forms to fill out. There is absolutely no need for that kind of doubling and tripling of paperwork.

This is just the hospital level. The increased cost of handling medicare patients alone according to this hospital report was $60,000 to $70,000 a year in this hospital. This is not taking into account the Federal bureaucracy that will have to be paid.

There is no way that I see that a Federal program can be cheaper.

Mr. ROSTENKOWSKI. I think we can't make the mistakes, as Dr. Christmas has alluded to, in national health that we made when we wrote the medicare program. I am hoping we can try the frugal road and squeeze the dollar but still get as much of a comprehensive program as this committee can put together in the near future.

as this committee can put together in the near future.

On another point, I, too, am disappointed in the fact that there are so many forms to fill out in government. It always seems that in government, there is just twice as much redtape as in the private sector. But maybe we can solve those problems, too.

At least I am hoping this committee can take that problem and solve it. Yes, Dr. Bryan.

Dr. BRYAN. Just one little thing. The young family who has children and cannot afford insurance—I have a 23-year-old son who thinks he is not earning enough to buy health insurance, and I have not purchased it for him.

I think if he went in, he could probably get on medicaid. In our proposal he could say I can buy this insurance because I am getting a tax credit for buying it or I can donate the money and get a tax deduction which is much less as far as the Government is concerned than having him on medicaid.

Anyway, this takes care of the 15 or 20 percent not covered. Anybody else could use it if he wants. The only work as far as the Government is concerned would be checking the receipts. That's all the paperwork. In fact, I'm sorry you are going to lose a lot of your local constituents because it would do away with 90 percent of HEW bureaucracy.

Mr. ROSTENKOWSKI. Is this the Clawson plan?

Dr. BRYAN. Yes, it's simple, logical, and does away with the bureaucracy.

Another is an example of a person earning $20,000 a year. He spends $5,000 as an exclusion. He pays his tax on $20,000 a year which is $4,380. He has bought his own insurance, $600 as an example, so he takes that credit away from $4,380 and pays $3,780 in taxes.

Now, that same family, if this goes to the ultimate where the insurance companies say they can do it with them using a $500 exclusion also at 80–20 up to $10,000 maximum, then the same family with the $20,000 income spends $500 out of pocket which is their deductible. They spend another $2,000 which is their 20 percent of $10,000. They might have had $30,000 heart surgery but have only had to put out $2,000 more. They have then paid on $18,000 which reduces their tax to $3,820, and they have a $600 credit for having bought their own insurance which reduces their tax to $3,220 so it encourages people to take care of themselves because they know they are never going to go bankrupt because of medical expense and the only part the Federal Government plays in it is the IRS when they use their receipts.

Mrs. KEYS. Mr. Chairman.

Mr. ROSTENKOWSKI. Mrs. Keys.

Mrs. KEYS. May I make one comment. Isn't it strange that somehow some of us refuse to recognize the tremendous amount of bureaucracy involved in the tremendous private health insurance sector of this country, the duplicating types of policies, eligibilities, the multiplied waste, the pluralistic way we handle our health bill with part of it government, part out of pocket, part private insurance?

Somehow we as leaders have today a tremendous job of making the public understand what we are losing in this fractionated kind of administration and what we lose in the bureaucracies we have.

Also, I think it has been aptly pointed out to us that in the area of education we have to make the public understand we are now paying a great amount of money in health and we should help rechannel that money so it would be much more beneficial and adequately spent for all.

Mr. Bryan. Another thing, the private health insurance industry tells me their bureaucracies, to remain competitive, has to cost them between 9 and 14 percent. In California they found the bureaucracy of administering medicaid cost 52 percent so the welfare patients were not getting the care they should.

The doctors were saying we won't be able to afford to take care of you because 74 percent of the malpractice suits were coming from this group of persons. They are dissatisfied because the money isn't paid for their care and they are slighted.

Mr. Rostenkowski. Gentlemen, thank you very much.

[A brief recess was taken.]

Mr. Rostenkowski. Welcome to the committee, gentlemen. I am sure you have been here long enough to know how the panel procedure operates. I will make this observation. There will be periods when the bills will ring and we will have to go over and record our presence.

Mr. Edwards?

PANEL CONSISTING OF MARVIN H. EDWARDS, OKLAHOMA CITY, OKLA.; MORGAN PAULEY, STATE CHAIRMAN, OKLAHOMA SECURITIES COMMITTEE; AND LYLE MERCER, EXECUTIVE SECRETARY, WASHINGTON COALITION FOR A NATIONAL HEALTH PROGRAM

Mr. Edwards. Thank you, Mr. Chairman. I represent no organization. I appreciate the opportunity to appear before this committee once again.

My name is Marvin Edwards. I am an attorney, a college professor, and a writer. I am also the author of a book entitled "Hazardous to Your Health," in which I presented what I believe to be the rather strong case, on the evidence, against national health insurance.

I am not a physician. For 5 years I was editor of a medical journal, but left that position in 1973 to come to Washington as a consultant on health care legislation to a number of your colleagues. I have no connection with the health care professions except that single vested interest that you and I share—the interest a prospective patient has in the quality of health care.

I suppose that, as usual, these hearings—and the legislation before Congress—are prompted by the supposed existence of a health care crisis. I assume that to be the argument, just as it was in 1900, and in the 1930's, and the 1950's, and in every year and every legislative session since.

The so-called crisis, however, is not supported by the facts.

Let's look for a moment at this case for national health insurance. Obviously, I cannot do justice to such an involved and important issue in a few minutes here today, but I assure you that I can and shall provide the members of this committee with adequate and substantial documentation of the material I am going to present today—material that is publicly available and taken from official Government sources, but generally ignored by those who advocate a change in the American health care system.

We are told there is a health care crisis—and yet Americans today are taller, heavier, healthier, and living longer lives than ever before.

We are told there is an infant mortality crisis—yet the infant mortality rate in this country has improved from 124.5 per 1,000 in 1900 to less than 19 per 1,000 today, and is better than the rate in any of the Common Market countries of Europe, all of which have national health programs.

We are told there is a major maldistribution of physicians, and yet a study by the Presidential Advisory Commission of Health Manpower found that 98 percent of the people in this country live within minutes of a major health care facility, and an independent university study revealed that most of the counties without private doctors either have very sparse populations—one, for example, has fewer people than my high school graduating class—or they are located adjacent to, and minutes away from, adjoining counties with large numbers of physicians and health care facilities.

We are told there is a serious shortage of physicians—yet the United States is increasing its production of physicians three times as fast as the increase in the population, and the doctor-patient ratio in this country is better than in any Common Market country.

And we are told there is a crisis in health care costs.

There is certainly no question that health care does cost a lot.

Thanks to Congress and its inability or unwillingness to restrain its public spending, everything costs a lot—our health care, our food, our housing, our clothing. Until the Congress does exhibit restraint and stops feeding inflation with $50 and $60 and $70 billion deficits, health care and everything else that is used in our daily lives is going to continue to cost a lot.

The question is whether health care costs are out of line with other cost increases and whether more Federal involvement will help the situation or make it worse.

During the late 1960's and early 1970's health care costs increased by 11.9 percent, and Members of Congress said the increase was outrageous and demanded that something be done about it. But during the same period of time, the cost of owning a home went up 18 percent, and the cost of buying meat in the grocery store went up nearly 14 percent. The increase in medical costs was about the same as the percentage of increase in the cost of clothing, shoes, and many other items in the economy, and I can add that you might compare that with the increase in the costs of postal stamps, congressional salaries, and other items.

That would suggest to me that perhaps the problem is not with the health care system but with the larger economic atmosphere it is a part of and in which it must operate.

Today the average American still spends less than 7 percent of his spendable income for health care, and works only 30 minutes to pay for that health care, compared to 2½ hours a day just to pay his taxes.

And national health insurance, gentlemen, will make health care cost more, not less.

Every major national health insurance proposal would cost billions of dollars at a time when the American people are already overtaxed by Federal spending.

And the figures you have are the estimates by the sponsors of those bills. As you may recall, medicare exceeded cost estimates by 41.1 percent in the first 5 years—and during those first 5 years the administrative cost of medicare—the cost for the form filling and paper shuffling and filling countless buildings and offices with countless bureaucrats—was more than $485 million.

A study by the Social Security Administration a couple of years ago indicated that the average American family of four was spending nearly $550 a year for health care—but would spend more than $1,200 a year in taxes to support the Health Security Act introduced by Senator Kennedy.

Mr. ROSTENKOWSKI. Excuse me, we will suspend for several minutes. We have to go vote and come right back.

Mr. EDWARDS. Please vote correctly.

[A brief recess was taken.]

Mr. COTTER [presiding]. Thank you. I think we are ready to resume, Mr. Edwards.

Mr. EDWARDS. I was pointing out that the average American family of four a few years ago was spending nearly $550 a year for health care, but would spend more than $1,200 a year to support the Health Security Act introduced by Senator Kennedy. And we have other evidence available, also. A study of all short-term general hospitals in Detroit revealed that in closed staff hospitals the hospitals employed more people, kept patients in the hospital longer, and cost twice as much per illness—$1,197 on the average, compared to $549 in private open-staff hospitals.

Well, if I'm not a physician, why am I so concerned about what you do? Because Congress threatens to build on this mountain of false premises a national health insurance system that seriously threatens the quality of the health care my wife and children will receive. No national health system in the world has provided medical care equal to the quality of care Americans now receive through private medical practice.

For example, one West German newspaper recently reported that in that country "Patients needing complex surgery are often forced to wait a matter of months or years * * *. Waiting lists of up to 6 months are looked upon as 'almost normal.' "

In England, hospitals are so overcrowded that patients are left lying in hallways, and at the end of 1971, there were more than half a million British patients on official Government waiting lists to get into hospitals. Is that the kind of system we want in this country?

Between 1948, the year the National Health Service was established, and 1962, 14 years later, not one new hospital was built in England. In that same period, 525 hospitals were built in the Southeastern United States.

And in Britain, Sweden, Germany, all throughout Europe, citizens are forced to labor under heavy tax burdens—heavier than our own, which are already too high—to pay for systems that provide impersonal and inferior assembly-line medical care.

Let us not add that burden to our own taxpayers, who are already paying $60,000 a minute just on the interest on the national debt. Let us not add that burden to our own American taxpayers, who already spend more out of each day's paycheck for their taxes than for their food, clothing, housing, and medical care combined.

Let me close with this comment. I have debated this issue across the country with advocates of national health insurance, and even with some of its congressional sponsors. They have eventually conceded each and every point I have made today. They have even admitted publicly that much to their regret there just is no public demand for national health insurance; a continued and loud demand by a few self-appointed spokesmen for the people, but as both national and local polls have shown, no demand by the people themselves.

But what point, finally, do these advocates of national health insurance come to? Just this: that when all is said and done, we need to enact a program of national health insurance because health care in this country is inequitably rendered; that the poor and the aged are not getting as good a quality of health care as the rest of us.

Well, if the poor and the aged are receiving inferior care, I would remind you that it is the poor and the aged—and the poor veterans in the veterans' hospitals we have been reading so much about—who already have national health insurance.

The poor and the aged have had national health insurance—medicare and medicaid—for 10 years. And if the quality of care they receive is inferior, then please, gentlemen, don't give it to the rest of us.

Mr. Cotter. Thank you very much, Mr. Edwards, for a fine presentation.

Mr. Pauley?

STATEMENT OF MORGAN PAULEY

Mr. Pauley. Mr. Chairman, I would like to preface my remarks by saying that I come from the same State as Mr. Edwards, and I did my undergraduate work and lived for a time in Mrs. Keys' home State of Kansas. Neither State is known as the mecca of Western civilization nor as a temple of Western liberalism.

Now, there are some things that any economist will agree on and those matters should become apparent in my speech.

Secondly, I would like to mention that Oklahoma had the distinction of having the first health maintenance organization in this country, and that was in the 1920's. It is unfortunate to remark that the AMA saw fit to remove those people from practice, and effectively they were forced out of the industry.

It is with those remarks that I begin. I am Bob Pauley, from Oklahoma State University. I don't represent the university at this hearing. I do represent the Oklahoma Coalition for Health Security Act.

The rationale for the consideration of national health insurance is straightforward and compelling. The health care industry is a $115 billion a year sector, and it is growing at tremendous speed. This expenditure on health care represents approximately 8 percent of our gross national product. Any industry that is represented as part of our national economy with such magnitude deserves the closest scrutiny.

The cost of medical care has increased dramatically in recent decades. During the period in the early seventies of wage-price controls, the cost of medical care increased at a rate of 10 percent. This far outstripped the rate of inflation nationally. The impact of a sector this size generating this type of price increase is of enormous import to the economy. This was, by and large, unattended inflation; that is, inflation that was not spurred by increases in productivity and technology. The anticipated rate of inflation for this fiscal year is expected to be much greater. The spiralling costs of the sector ought then to be a concern of all without regard to conservative or liberal economics.

I don't think I need to remind the members of this committee that the unattended inflation is not justifiable. That is to say, there is no increase in technology nor in delivery of medical care to warrant that inflation in the sector.

Is the cost of health care justified? The question in part was answered above. Analysis ought to be made on the basis of cost and benefits accrued to the society. The average consumer spends approximately 1 month's income per annum on health care, and this does not conflict with what Dr. Edwards said earlier. And this proportion is increasing. Illness is not related to income, yet quality care is positively related to income. That is to say, a poor person could suffer a myocardial infarction just as surely as an affluent person. The poorer person, if he is allowed treatment, will pay a far greater proportion of his income than the more prosperous individual. To the extent that this is true, the richer a person is, the greater the likelihood that he can avail himself to quality care. Fee for service enforces this structure. Those who do not favor a prepayment method are accepting this unfortunate dichotomy as an economic way of life. Hospitals in Oklahoma are not compelled to pay property taxes, yet they are not required to serve all citizens of Oklahoma. The result is an increase in incidence for those least able to pay. In other words, these hospitals are a demander of public services and benefits from using these services; yet, they do not pay for them. The tax burden is shifted, increasing the regressivity of the property tax. Consider the evidence in Oklahoma alone.

I invite you to turn to tables 1 and 2 and the pages prepared by the Oklahoma Health Planning Commission where it indicates that the health care procedures in North Tulsa where the predominant indigent care and lower middle income persons reside with an average income of $5,790 per year, they have only 3 percent of the health care providers, 1.8 of dental and mental health care providers, and zero percentage of the hospitals. There is only one hospital in Tulsa responsible for this care and this is Hillcrest Medical Center. The rest of those hospitals, it was brought out in State legislative hearings, have a practice of charging admission fees. They will take care of major crisis care, but not for protected illness. They will shift those to Hillcrest or the University Hospital in Oklahoma City.

To the extent that this is true, there are only two primary deliverers of care to low-income groups. The fee for service compels the maldistribution of medical care facilities, and the moderate- and low-income groups are the groups that suffer as a direct consequence. National health insurance of the type proposed by Senator Kennedy and Congressman Corman would not make family income a predeterminate of quality care.

In the recent past, this Nation has noted an excess of surgical specialists. An economic rule of thumb is that excess supply will cause prices to fall. It would be reasonable to expect a fall in prices of surgery. Empirically, prices have gone up, and the incidence of surgery has dramatically increased. Well, what is wrong? To compensate for increased surgical talent, surgeons are performing more unnecessary elective operations. One study estimated that the number of such unnecessary elective operations totaled three and two-tenths million operations per year, at a welfare loss to consumers of approximately $5 billion a year. Another study by Johns Hopkins University found that elective surgery increased markedly three times a year; once before taxes, once before Christmas, and once before vacations. Strange how that works. Recently in the Wall Street Journal, they reported that the Justice Department is presently pursuing antitrust action against anethesiologists for price fixing. They have a common practice of sending price lists to 90 percent of the anethesiologists who comprise the membership. To the extent that is true the Justice Department may find this to be a common practice of the medical industry as a whole.

Private health insurance compels excessive costs as well. The insurance firms have deductibles to in part assure that patients and clients will not abuse their services. What is the real effect? A patient in order to get payment might order more medical services than he would have opted for otherwise. He might choose, for example, to have an operation that he had previously postponed, or he and/or his physicians might wish to extend his period of hospitalization. The cost to the consumer is represented, and caused by increased costs of insurance. Every time the insurance company comes before the insurance board to increase prices, what they are saying is demand is greater and they feel justified in raising their prices of health insurance. Well, I would agree with that, but in large part it is promoted by the practice of deductibles which the insurance companies find so attractive, the costs of insurance are not positively related to income as such on an assurity basis; the poorer pay is disproportionately large segment of their income. That is that an insurance firm, using statistical methods, will compute the risks for a group with little variation for income. Thus, this has some aspects of regressivity. Ignoring the cost argument for a moment, can we assume that private insurance solves the payment problems? No; quite the opposite. Few insurance companies would cover catastrophic injury. Moreover, a significant portion of our population is not covered by insurance at all, or in large part.

The problem on balance is that there are no intrinsic advantages to the current approach to health insurance. If one is affluent, one can afford coverage, and if one is extremely affluent, one can most probably afford the high cost of catastrophic illness. For those who are not so fortunate, such coverage cannot be afforded. For those who can afford some coverage, by and large, it is not sufficient to meet all contingencies.

Hospitals, not unlike any other firm, must seek to maximize profits or at least to minimize losses. Consider discussion in the early stages of this paper of the problems of maldistribution of medical facilities. Most commonly this is caused by the determinate for fees. The hospital is funded by and survives by the levels of occupancy it maintains. Is not the propinquity for abuse present; To wit, that physicians in residence at that particular hospital will keep the more affluent in the hospital longer in order to keep the hospital solvent? Moreover, a hospital will charge what the market will bear, empirically, this is justified by the price determinants.

How can the medical industry charge more than a fair price? The reason that prices are higher than market prices would otherwise dictate is that there is little competition in this industry. Qualified persons are denied admission to practice or admission to enter training in medical disciplines. The AMA contracted for a study in which they found an excess of surgeons and the study concluded they would be overwhelmed by surgeons. The response by the AMA was to cut back on the number of surgeons.

This would not be the economic response to it. The economic response would be to let them go into surgery and increase the number of people going into general practice by increasing the number of people being admitted to medical schools. The AMA response keeps the demand for medical practitioner high. By causing shortages, one can force a maldistribution and thereby charge exhorbitant prices. The practice of deductibles insures a higher cost in the area of private health insurance, industrywide. The competition among hospitals is virtually nonexistent. That is, a physician who is in residence at a given hospital will, with few exceptions, refer all his patients to that hospital. A patient has no way of knowing what hospital is better, cheaper, and of most benefit to him. In addition to this, a patient has no knowledge in the general sense to determine what tests, if any, are absolutely essential to his expeditious recovery. To the extent that this is true, the lack of competition in the medical industries leads in a causal sense to higher prices to the detriment of the consumer.

The final broad area of indictment to be covered is the philosophical intents and realities of the status quo. The present system practices predominantly curative and crisis care. That is to say that a consumer will not seek diagnosis or treatment unless the illness becomes exacerbated. To be sure, a significant problem is consumer ignorance. This is an additudinal problem that will not be alleviated by any legislative methods. To the extent that cost inhibits search for treatment, this could be significantly reduced by national health insurance. The Kennedy-Corman bill places the emphasis correctly. Manpower, paid on a capitation basis, means that it is of preeminent import to keep patients well and happy. It provides for the necessary freedom of choice that would enable both parties to agree on what services could be rendered. It reduces the barrier in costs so that price of an office call or hospitalization will no longer be an impediment to quality preventive or noncrisis care.

As a philosophical tenet, I would opt for private industry and enterprise as opposed to governmental programs. To the extent it is related to the health insurance as a whole or national health insurance, there has been no competition in this industry. To the extent this is true, we have experienced a significant consumer welfare loss.

The recalcitrance of the industry to change for the sake of the consumer is surpassed only by the structural inefficiencies endemic to health care industry. Yet, the position of those who purport to be dues-paying members and standard bearers of competition has swept this country just as surely as the inquisition swept Spain.

Primarily, it is of little purpose to express a rationale for a proposal without justification that it would solve the problems described as inherent to the status quo. Make no mistake about it, the Health Securities Act as not a panacea for the problems of this Nation's health care would at least make significant inroads into alleviation of these problems. As mentioned in the early stages of this paper, the Kennedy-Corman bill would place the emphasis on preventive or noncrisis care. The accrual advantages are numerous. It would allow for market structures to determine supply and demand for physicians and for health professionals and facilities. It would reduce the artificially high prices caused by deductibles. It would reduce the length of hospitalization and the occurrence of unnecessary hospitalization. Moreover, the amount of man-days lost per year might be reduced significantly, and, if so, could raise the real GNP. This would be an extra advantage which might accrue.

Detractors advance the argument that economic considerations render the Health Securities Act undesirable and unfeasible. There is a paucity of information that would lend any credence to this argument. The money is already being spent; there is already a large leviathan of a health industry; we would, then, be creating no new industry or no new bureaucracy. That is, it would not entail any new money. It is said that this will increase our taxes. Our taxes would be increased, this is correct. However, the personal income would not fall. You would be spending the same or slightly less than the amount consumers presently spend for health care. Personal income then would not fall.

This would be tied to the personal income tax and corporate income tax. As such, it would be on balance (1) more progressive than the present fee for service methods; (2) this would take the place of direct payments to primary, secondary, or tertiary deliverers of health care products. On balance, the consumer would not pay more but would instead accrue more benefits. Many argue that it would increase the deficit. Some have argued that it would increase taxes as well as the deficit from an economic point of view this makes no sense at all. What you are, in effect doing, is balancing the budget. That is essentially what the Kennedy-Corman bill does as described here. Because of financing by taxes equal to Government expenditures, it would not normally add to the deficit. Even if it were financed out of Treasury bond sales, a Keynesian would generally find little problem with this, in time of recession.

The central fact remains that the Health Securities Act would not increase the national debt in the normal case. Another argument in favor of such a proposal is that the tax collection would be administered by the Internal Revenue Service, and as such one could reasonably expect some advantages of economies of scale. The important feature here is that the Health Securities Act, in terms of economic justice and economic efficiency, is a compelling and decisive comparative advantage over the status quo. In other words, detractors never contend that the fee for service has egalitarian significance. This act would reduce overlapping of existing payment sources; that is, health insurance, medicare-medicaid, and should be of advantage to everyone concerned. In terms of administrative costs the Department of HEW spends about 5 percent of their budget on administration as opposed to about 16 percent for private health insurance. The indictment that a Federal bureaucracy is comparatively inefficient is without significant empirical justification. Moreover, the costs of administration, across the board, should be reduced. Presently, a doctor may get paid from second or third parties or a combination of them. The morass of paperwork involved would be reduced. Many supporters of the status quo argue that the quality of care would be reduced. However, the Health Securities Act would be utilizing the same resources that are presently being employed.

If we are going to use the same resources, opponents can't deny we will have the same quality of health care under the national health insurance programs as we currently enjoy. There is also the assumption that we have quality now. I would agree, for the most part, the overall mortality rate has gone down. I call your attention, however, to table 1 and table 2 and I might note that the health indexes for North Tulsa combined compare favorably with those of Oklahoma and those of the Nation. North Tulsa taken separately is a different story. There were 46.3 deaths, infant mortality, per thousand live births. For South Tulsa, the richer section of town, the infant mortality was 18.8 percent, and in eight tracts, all in higher economic groups, they had rates below 10 percent.

So the argument that you are receiving quality health care now is somewhat mitigated. To the extent that it is true we receive quality health care, I would make this one point. You do receive quality care that is in fact true. But empirically, it has only been for those people that can afford it.

The Health Securities Act would be a structural comparative advantage over the duplication, maldistribution, and economically inefficient fee-for-service method of payment. Quality physicians should be rewarded, a reestablishment of competition would insure this. When the AMA argues that this Nation has the finest medical industry in the world in terms of physician care and skills, they are correct to the greater extent. Yet, the present system only insures this care to the very wealthy. The status quo has fought change and structurally cannot change. The Health Securities Act is the only equitable, efficient, and comprehensive program for change. And I would again invite your attention to the report prepared by the Oklahoma Health Planning Commission where it indicates on the first page and the second page its recommendations and among those it indicates that adequate medical care should be provided for all Oklahomans regardless of the individual's ability to pay for such care.

Thank you, Mr. Chairman.

[Material appended to Mr. Pauley's statement follows:]

TABLE 1

	Number of families	Median family income	Population
District—			
25	5,881	8,280	25,000
2	7,693	5,234	22,667
3	6,489	8,030	31,648
16	6,364	8,809	22,948
Total	26,427	30,362	102,263

MEDIAN PER-CAPITA INCOME—7,590

Health care providers for North Tulsa: 3 percent of the health physicians providers; 1.8 percent of dental and mental health care providers; 0 percent of the hospitals.[1]

TABLE 2

	Number of families	Median family income	Population
District—			
5	11,433	11,610	41,125
6	13,427	12,497	47,498
17	6,467	11,967	24,122
18	11,351	14,693	42,295
Total	43,058	12,718	155,040

Health care providers for South Tulsa: 97 percent of the physicians providers (est. 600); 98.2 percent of the dental and mental health providers; 100.0 percent of the hospitals including 6 major hospitals and one minor hospital.

Health care for North Tulsa has been limited to crisis or sickness care. The Moton Health Clinic, in North Tulsa, has, in large part provided this type of care. This is strictly ambulatory in nature however.

The health indices for North Tulsa and South Tulsa combined compare favorably with those of Oklahoma and for the Nation. North Tulsa, taken separately, is quite a different story. In North Tulsa, there were 46.3 deaths (infant mortality) per 1,000 live births. For South Tulsa, the infant mortality rate was 18.8, and 8 tracts, all in high socioeconomic areas, had rates below 10.

Report on Charity Care Policies and Practices of Oklahoma Hospitals by Oklahoma Health Planning Commission, Oklahoma City, Okla.

I. CHARGE AND METHODS

The creation of a Special Council Committee on Charity Care was requested by the Oklahoma Health Planning Commission on April 22, 1974. It was charged to examine and report findings and recommendations on the following:

1. Determine Charity Care Policies and Practices of Oklahoma Hospitals.
2. Agree upon criteria for use in assessing the equity of hospital charity care practices.
3. Identify means by which the responsibility for charity care could be shared equitably among acute care hospitals.

Due to the short time available to carry out the mission, the Committee determined that it would not undertake specific surveys to develop information, but would use data already available. Public hearings were held and the full Council publicly debated the findings and recommendations.

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[1] Only the Hilcrest Medical Center has been a consistent and primary deliverer for this segment of the population.

Data: 1970 Census.

II. SUMMARY

A. Findings

1. Hospitals in metropolitan areas where working poor people live had a disproportionate number of indigent patients, and were therefore bearing much of the cost for such care.

2. Hospitals with outpatient clinics provided a high percentage of indigent care.

3. In Oklahoma, where 50% of the population has incomes within 100% above the poverty line, the amount of charity care given may be low in relationship to the number of possible indigents.

4. Some hospitals do require pre-admission deposits.

5. Hospitals do not require deposits of emergency patients.

6. Affidavits have been provided which indicate that under certain circumstances some hospitals in Oklahoma City turn away patients because of their inability to pay a deposit.

7. Most hospitals do provide care to patients who meet their criteria for medical indigency and come to their hospital for admission.

8. University and Hillcrest are assuming 34% of the reported charity care costs in the State.

9. Part of the cost associated with care at University Hospital is educational cost, and should be recognized as such.

10. Hospitals are severely hampered by Medicare and Medicaid's refusal to allow bad debts and charity care as a reimbursable cost of doing business.

B. Criterion and standards for assessing the equity of hospital charity care practices

1. *Criterion.*—Hospitals should provide medical treatment to those who are unable to pay all or part of the charges, and divide such care equitably among themselves, each to the extent of its financial ability.

2. *Standards.*—

a. The amount of charity care provided should be related to the annual value of tax relief from federal sources under 501(c)(3), and from ad valorem taxation. This is in addition to any Hill-Burton requirements.

b. Each public and non-profit hospital should give approximately the same percentage of its net operating costs in indigent care. Endowed indigent care and educational funds would not be included in operating costs.

C. Recommendations

1. That adequate medical care be provided to all Oklahomans, regardless of individual ability to pay for such care.

2. That no hospital be unduly burdened financially by the provision of care for those unable to pay. Hospitals cannot be expected to bear the total burden of indigent care in the state.

3. That the costs of charity care be shared and not the actual load of charity patients.

4. That a means be devised to equitably share the costs of charity care, according to the following definitions:

(a) *Charity care.*—Medical services provided individuals who have neither personal resources to pay for the medical services they need, nor a third party mechanism to make payment in their behalf.

(b) *Equity.*—Charity care costs shared fairly among acute care hospitals.

(c) *Fair.*—The proportion of number of total patients served to the number of charity care patients is approximately equal among hospitals according to ability.

(d) *Ability.*—The dollar amount of charity care and treatment a hospital can provide without:

(1) Impairing its ability to meet current operational expenses for inpatient departments, and

(2) Losing its capacity to provide community and patient services at current volume levels.

5. That a State Rate Review Program be authorized to set rates.

III. APPROACH AND ALTERNATIVES

A. Policy

1. Establishment of an open door policy for all non-profit voluntary and local or state governmentally sponsored hospitals, aided by the abolition of a pre-admission deposit.

Plus

(a) Adoption of the Medicare language relating to pre-admission deposits. "301 A. General Prohibition Against Requiring Prepayment As A Condition of Admission. Hospitals may not require from a prospective patient or from someone on his behalf, advance payment . . . as a condition of admission for inpatient services. . . ." 405.610(b) "A provider of services may not deny . . . inpatient services to an individual . . . on the ground of his inability or failure to pay requested amount at or before admission."

Plus

(b) Advertisement that any person seeking admission for medically indicated reasons is entitled to formal admission to the hospital prior to responding to inquiries into his or her financial status. (Hill-Burton regulations stipulate that a patient must be determined to be a charity care patient at the time of admission.)

B. Sharing among hospitals

1. The pooling of funds for indigent care by hospitals to be administered by a State Agency.

Or

2. The pooling of funds for indigent care by hospitals within Oklahoma's Health Planning Areas to be administered by an Area Health Planning Organization.

Or

3. The assessment of in "lieu-of" ad valorem taxes to be paid into State or Area administered fund for indigent care use.

Or

4. The provision of an opportunity for hospitals to work with a negotiator on a means of solving this problem and then to report back to the Commission or other appropriate public body, a proposed solution amenable to the hospitals.

V. LEGAL ASPECTS

A. County responsibility:

The State Constitution provides that the poor will be cared for by the county governments in accordance with Section 3 of Article XVIII.

> "Article XVIII—Counties
>
> Section 3—Provision for persons in need. The several counties of the State shall provide, *as may be prescribed by law*, for those inhabitants who, by reason of age, infirmity or misfortune, may have claims upon the sympathy and aid of the county." (Emphasis supplied)

Although county governments were required to care for the poor, no statutes have been prescribed for this purpose. Prior to 1951, most county governments budgeted funds for providing some services to the poor. Most county commissioners used "charity funds" that were budgeted for furnishing food for indigent citizens residing in the county or for burial of paupers. Later, some county governments negotiated contracts with the local hospitals to pay for a limited amount of hospital care for indigent citizens as approved by the County Commissioners. Until 1951, many county governments also arranged to purchase hospital care for indigent citizens who were admitted to the University Hospital.

On November 20, 1951, the Supreme Court of Oklahoma ruled, in the case of Battles vs. the State, that a State institution must be maintained at the expense of the State. After this ruling, county funds could no longer be used for payment of services of the Oklahoma University Medical Center or other hospitals operated by the State.

But, most counties did provide for payment of hospital care for a limited number of indigent residents until 1957, the year that the Oklahoma Department of Public Welfare adopted a Medical Care Program for recipients of "categorical assistance." After this date, most county governments, with the exception of Oklahoma and Tulsa counties, used their "charity funds" to pay for services for the poor other than hospital and medical care.

> Title 19, Chapter 17, Section 790.1 (4), states that ". . . it shall be the duty of the board of control to admit, without charges, to the county hospital, all indigent patients certified to be such by said board of control, in need of medical or surgical treatment. . . ."

Apparently this means that any county which operates a county hospital is responsible for treating indigent patients who present themselves to that hospital. The burden rests primarily on the hospital and secondarily on the county.

B. Hospital responsibility

A number of direct and indirect public subsidies for voluntary, non-profit hospitals have developed over the years as a matter of public policy. These advantages were provided in recognition of the expectation that such hospitals would perform services which the State or Federal Government would have to provide were it not for voluntary, non-profit hospitals.

Among the advantages provided voluntary non-profit hospitals are:

No advalorem taxes on property.

No taxes on excesses of income over expenses.

Individuals contributing to such hospitals are allowed to deduct their contributions from their income for tax purposes.

Through the Oklahoma Public Trust Laws, hospitals are able to borrow capital, repayable from revenues, through quasi-public (but not fully publicly accountable) bodies in whose affairs a city, county or state general purpose government has taken a beneficial interest. (This makes the interest rate lower, because the yield to buyers is not subject to taxation).

Federal grants and contracts are awarded to public and non-profit hospitals and health care institutions (Hill-Burton is but one example).

B. University Hospital's charity care was $843,468. This is 6.5 percent of its Gross Patient Revenue.

C. The following table presents charity care as a percentage of the Gross Patient Revenues, aggregated into classes of hospitals according to assets. (Data source: 48 of the 83 hospitals, subject to the Hill-Burton Regulation).

Assets:	*Percent of charity/GPR (total billed charges)*
$200,000 to $699,000 (9 hospitals)	335/1000ths of 1 percent.
$700,000 to $999,999 (7 hospitals)	233/1000ths of 1 percent.
$1,000,000 to $1,999,999 (11 hospitals)	608/1000ths of 1 percent.
$2,000,000 to $9,999,999 (14 hospitals)	816/1000ths of 1 percent.
$10,000,000 and up (7 hospitals)	3.34 percent (with university) 2.81 percent (without university); 2.29 percent (without university and hillcrest).

D. Charity care in the Tulsa and Oklahoma City metropolitan areas

	Gross patient revenues	Contractual adjustments	Charity	Bad debts	Total reductions
With university and Hillcrest	$163, 970, 033	$12, 077, 486	$4, 116, 323	$4, 854, 260	$21, 048, 075
Without university and Hillcrest	$131, 647, 840	$8, 249, 354	$2, 217, 853	$2, 792, 039	$13, 259, 252
Percent given by university and Hillcrest	20	32	46	42	37

E. Charity care statewide

	Gross patient revenues	Contractual adjustments	Charity	Bad debts	Total reductions
All hospitals	$305, 678, 501	$21, 802, 640	$5, 580, 987	$9, 025, 622	$36, 409, 249
All but University and Hillcrest	$273, 356, 308	$17, 974, 508	$3, 682, 517	$6, 963, 401	$28, 620, 426
Percent given by University and Hillcrest	11	18	34	23	21

F. What these tables indicate

1. Hillcrest and University do 34% of the charity care in the State of Oklahoma. They have 9% of the real revenue* of the State's hospitals.
2. These two institutions provide 46% of the charity care in the urban areas. They have 17% of the real revenue of the hospitals in the metropolitan areas.
3. University Hospital provides 43% of the charity care in the Oklahoma City Area; Hillcrest gives 49% of the charity care in the Tulsa Area.

---

*Real revenue is the sum obtained by subtracting total reductions from gross patient revenues (billed charges).

4. Charity care data include care given to Medicare and/or Medicaid (usually Medicaid) patients which is not covered by the contracted benefits. In certain cases they also include courtesy discounts granted employees.

G. Although these data show that University provides a large percentage of medical care for the indigent, there are probably reasons for this.

1. University may need indigent patients for teaching purposes. Since University's daily cost is considerably higher than other hospitals, some parts of the costs of care at University must be attributable to the teaching functions, not patient care per se.

2. University's average daily cost is $186, as opposed to $125 for other Oklahoma City hospitals. This aspect, which will be compounded by the two medical schools in Tulsa, will probably need to be addressed before it reaches the Oklahoma City dimension.

3. The average daily charges for the Tulsa and Oklahoma City hospitals are as follows:

Tulsa	
A	$116.62
B	93.24
C	132.87
D	109.39
E	114.20
F	116.72
Average	113.84

Oklahoma City	
G	$105.36
H	112.62
I	103.30
J	116.26
K	122.49
L	155.58
M	119.10
N	118.60
O	112.75
P	186.00
Average	125.21

Combined average, $120.94.

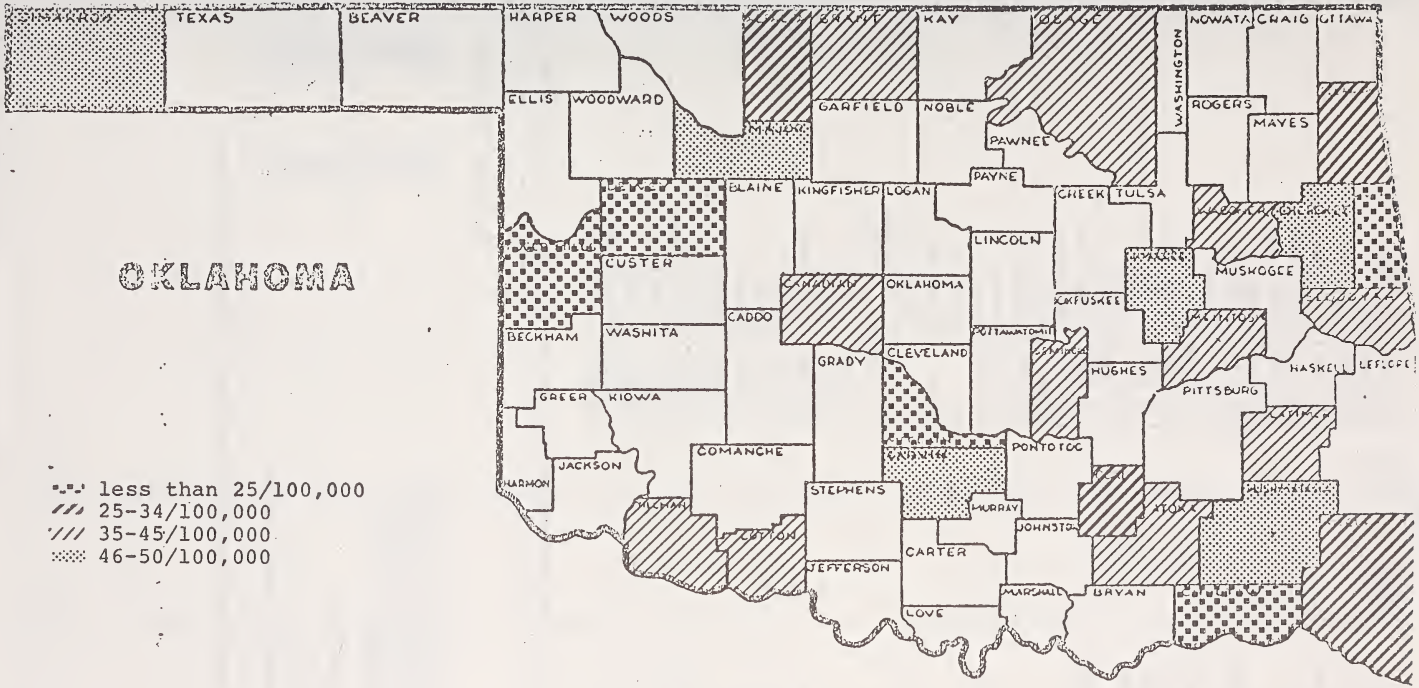
H. Charity Care: Measures of Comparative Efforts by Oklahoma Hospitals: This section attempts to further assess the charity care efforts of Oklahoma hospitals in cognitive mathematical terms which begin to address the criteria of Equity, Fairness, and Ability. Although these definitions may be found elsewhere in the report, they are repeated here to enable easy reference.

Charity care.—Medical services provided individuals who have neither personal resources to pay for the medical services they need, nor a third party mechanism to make payment in their behalf.

Equity.—Charity care costs shared fairly among acute care hospitals.

Fair.—The proportion of number of total patients served to the number of charity care patients is approximately equal among hospitals according to ability.

Counties with 50 or less physicians per 100,000 people.


OKLAHOMA
less than 25/100,000
25-34/100,000
35-45/100,000
46-50/100,000
TEXAS
BEAVER
HARPER
WOODS
KAY
WASHINGTON
NOWATA
CRAIG
OTTAWA
ELLIS
WOODWARD
MAJOR
GARFIELD
NOBLE
PAWNEE
PAYNE
ROGERS
MAYES
BLAINE
KINGFISHER
LOGAN
CREEK
TULSA
CUSTER
LINCOLN
OKLAHOMA
MUSKOGEE
OKFUSKEE
BECKHAM
WASHITA
CADDO
POTTAWATOMIE
GRADY
CLEVELAND
HUGHES
HASKELL
LEFLORE
GREER
KIOWA
PITTSBURG
PONTOTOC
COMANCHE
HARMON
JACKSON
STEPHENS
MURRAY
JOHNSTON
CARTER
JEFFERSON
MARSHALL
BRYAN
LOVE

	Physicians/Population
Adair	1/4, 125
Alfalfa	1/3, 550
Atoka	1/2, 300
Beaver	1/1, 967
Beckham	1/1, 300
Blaine	1/1, 525
Bryan	1/1, 663
Caddo	1/1, 956
Canadian	1/2, 506
Carter	1/829
Cherokee	1/2, 025
Choctaw	1/4, 275
Cimarron	1/2, 000
Cleveland	1/841
Coal	1/2, 900
Comanche	1/1, 622
Cotton	1/2, 200
Craig	1/507
Creek	1/1, 908
Custer	1/1, 014
Delaware	1/3, 233
Dewey	0/
Ellis	1/638
Garfield	1/761
Garvin	1/2, 054
Grady	1/1, 162
Grant	1/2, 333
Greer	1/1, 620
Harmon	1/1, 567
Harper	1/1, 225
Haskell	1/1, 371
Hughes	1/1, 085
Jackson	1/1, 383
Jefferson	1/1, 300
Johnston	1/2, 767
Kay	1/869
Kingfisher	1/1, 145
Kiowa	1/1, 700
Latimer	1/2, 375

	Physicians/Population
Le Flore	1/1, 614
Lincoln	1/1, 918
Logan	1/1, 908
Love	1/1, 280
McClean	1/4, 500
McCurtain	1/3, 155
McIntosh	1/2, 200
Major	1/2, 000
Marshall	1/1, 680
Mayes	1/1, 280
Murray	1/1, 543
Muskogee	1/719
Noble	1/1, 700
Nowata	1/2, 080
Okfuskee	1/1, 867
Oklahoma	1/465
Okmulgee	1/1, 984
Osage	1/2, 890
Ottawa	1/1, 525
Pawnee	1/1, 563
Payne	1/1, 883
Pittsburg	1/1, 103
Pontotoc	1/869
Pottawatomie	1/1, 305
Pushmataha	1/2, 000
Roger Mills	1/4, 300
Rogers	1/1, 342
Seminole	1/2, 555
Sequoyah	1/2, 844
Stephens	1/1, 575
Texas	1/1, 467
Tillman	1/2, 480
Tulsa	1/516
Wagoner	1/2, 610
Washington	1/710
Washita	1/1, 843
Woods	1/1, 350
Woodward	1/861

DISTRIBUTION OF OKLAHOMA PHYSICIANS ELIGIBLE FOR PRACTICE, OCT. 15, 1965, COMPARED TO OCT. 15, 1975

	Oct. 15, 1965	Oct. 15, 1975	Increase or decrease
Cities with populations over 100,000	1, 193	1, 706	+513
Cities with populations 10,000 to 100,000	605	844	+239
Cities with populations 5,000 to 10,000	180	187	+7
Cities with populations 2,500 to 5,000	125	99	−26
Cities with populations under 2,500	163	106	−57
Total in the State	2, 266	2, 942	+676
Out of State	901	1, 616	+715
In military service	140	132	−8
Total eligible for practice in the State	3, 307	4, 690	+1, 383

Note: Does not include temporary licenses or certificates for limited institutional practice.

County	Number of—		Total number of physicians
	Medical doctor [1]	Doctor of osteopathy	
Adair	3	1	4
Alfalfa	2	----	2
Atoka	2	3	5
Beaver	3	----	3
Beckham	12	----	12
Blaine	7	1	8
Bryan	13	3	16
Caddo	12	4	16
Canadian	15	3	18
Carter	41	7	48
Cherokee	6	6	12
Choctaw	3	1	4
Cimarron	2	----	2
Cleveland	117	5	122
Coal	2	----	2
Comanche	64	1	65
Cotton	1	2	3
Craig	27	2	29
Creek	18	7	25
Custer	18	4	22
Delaware	6	----	6
Dewey	0	0	0
Ellis	8	----	8
Garfield	59	17	76
Garvin	9	4	13
Grady	26	3	29
Grant	1	2	3
Greer	5	----	5
Harmon	3	----	3
Harper	4	----	4
Haskell	2	5	7
Hughes	12	1	13
Jackson	23	1	24
Jefferson	6	----	6
Johnston	3	----	3
Kay	52	3	55
Kingfisher	8	3	11
Kiowa	5	2	7
Latimer	1	3	4
Leflore	13	8	21
Lincoln	8	3	11
Logan	10	2	12
Love	1	4	5
McClain	4	----	4
McCurtain	5	6	11
McIntosh	4	2	4
Major	1	3	6
Marshall	2	3	5
Mayes	11	9	20
Murray	4	3	7
Muskogee	84	2	86
Moble	5	1	6
Nowata	2	3	5
Nkfuskee	5	1	6
Oklahoma	1, 124	62	1, 186
Okmulgee	15	4	19
Osage	9	1	10
Ottawa	12	8	20
Pawnee	5	3	8
Payne	45	1	46
Pittsburg	32	2	34
Pontotoc	35	----	35
Pottawatomie	36	2	38
Pushmataha	3	2	5
Roger Mills	1	----	1
Rogers	18	6	24
Seminole	10	1	11
Sequoyah	5	4	9
Stephens	24	3	27
Texas	8	4	12
Tillman	4	1	5
Tulsa	611	195	806
Wagoner	2	8	10
Washington	58	----	58
Washita	6	1	7
Woods	7	1	8
Woodward	15	3	18
Total	2, 845	456	3, 301

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[1] Taken from OSMA Medical Director, 1975.

[2] Taken from Oklahoma Osteopathic Association 76th Annual Directory 1975–76.

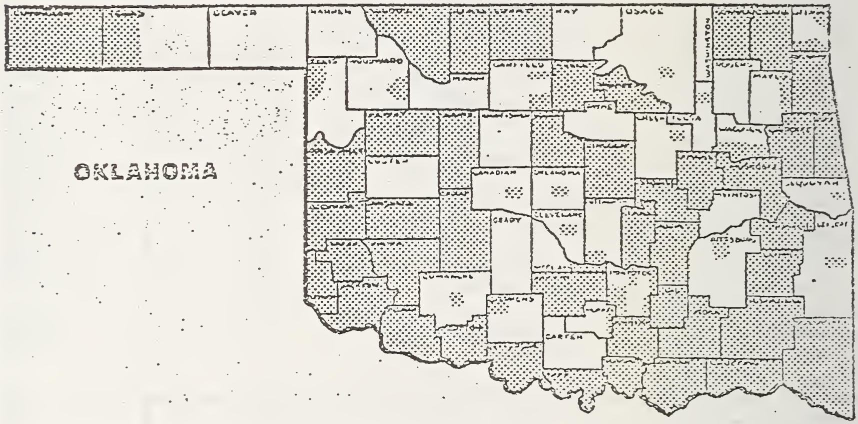
HEALTH SHORTAGE AREAS

Several Federal programs which are designed to improve the geographical distribution of health manpower and services require the designation of underserved areas. Each program utilizes a different set of criteria, depending on its goals and objectives.

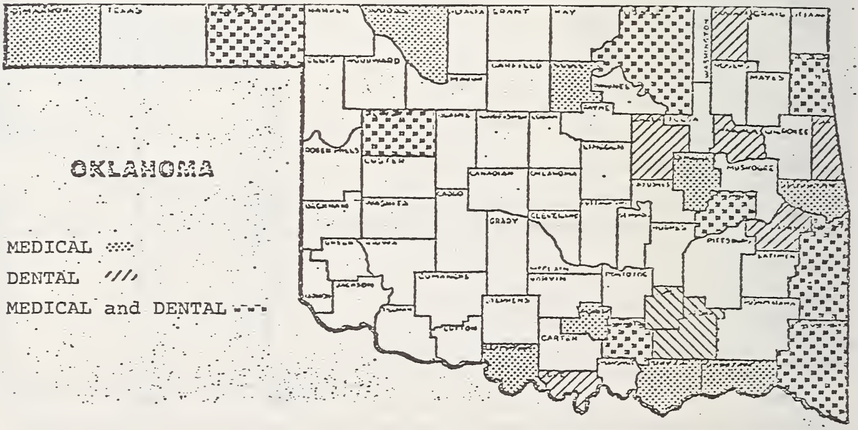
The area designation process for programs which are designed to alleviate shortages of specific categories of health manpower is centralized in the Bureau of Health Manpower. Programs included in this process are National Health Service Corps, which is a placement program for physicians and dentists, loan forgiveness for physicians and loan forgiveness for nurses. Maps 2 and 3 represent areas which qualify under two of these programs.

The second designation process is one which attempts to identify areas which have inadequate levels of health services, because of factors such as insufficient resources, inadequate organization or inadequate access to available resources. These efforts are concentrated in the Bureau of Community Health Services. Map 1 represents areas in Oklahoma which qualify under one of these programs, which is concerned with locating health maintenance organizations in medically underserved areas.

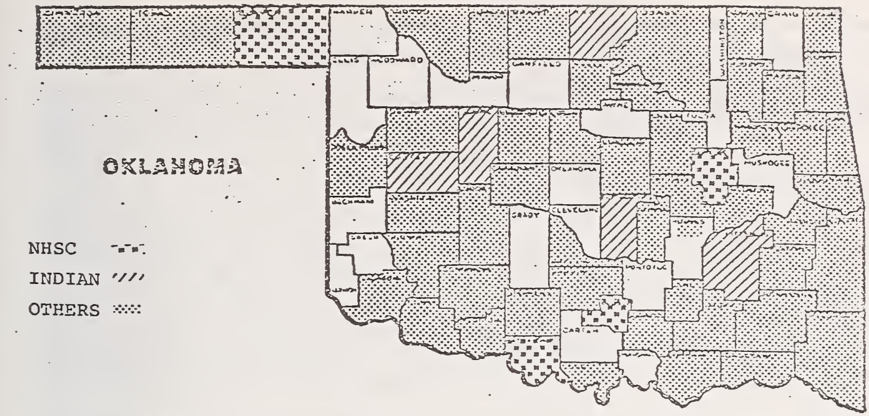
Information on any of these programs may be obtained by contacting the Oklahoma Helath Planning Commission, N.E. 10th & Stonewall, Oklahoma City, 73105; 405–271–5161.



Map 1.—Medically underserved areas—Health maintenance organizations



Map 2.—National Health Service Corps—Shortage area



MAP 3.—Physician shortage areas—Section 741(f) Public Health Service Act

Mr. ROSTENKOWSKI (presiding). Thank you, Mr. Pauley.

Mr. Mercer?

STATEMENT OF LYLE MERCER

Mr. MERCER. Mr. Chairman, and members of the committee, I am Lyle Mercer, executive secretary of the Washington Coalition for a National Health Program on whose behalf I appear today to testify in support of the Health Security Act.

The Washington Coalition was organized in 1973 by a grouping of leaders of trade union, church, elder citizen, health and other community organizations.

Some 400 persons from 70 groups participated in our first statewide conference in Seattle, heard proponents of the various national health measures, evaluated the proposals in workshops. At the closing plenary session, the attendants endorsed the Health Security Act and opposed the catastrophic approach by a virtually unanimous vote.

An affiliate of the Health Security Action Council, the Washington Coalition is committed to the educational and political action which shall lead to the establishment of a national health care system which provides:

Comprehensive health care as a right for all U.S. residents;

Equitable financing by Federal social insurance and general tax revenues;

Reorganization of the delivery mechanism to ensure equal, efficient and quality health care;

Provision for adequate health personnel, services and facilities;

Guaranteed accountability and responsiveness to the public by means of consumer participation in the establishment, implementation and oversight of a rational national health care system.

HEALTH CARE NEEDS IN WASHINGTON

The State of Washington was a pioneer in the development of prepaid health insurance programs. And, in the 1930's, via legislation and the initiative process, it initiated health care coverage for welfare recipients, the aged, blind and dependent children.

Twenty-eight years ago, trade unionists, members of the Grange and other cooperators founded Group Health Cooperative of Puget Sound. Today, the cooperative provides high quality cost controlled health care to over 200,000 consumers in the area. The Nation's largest member-owned and governed prepaid group practice plan, it is widely cited as a model in the field of health care delivery. As a member of the cooperative's board of trustees, I can report that one of our lay leaders will be testifying during a later stage of these hearings.

Despite our gains, the people of our State are of necessity demanding enactment of a national health program which will eliminate continuing gross inequities which result in inexcusable suffering and criminaly shortened lives, both in Washington and throughout the Nation.

The report of Governor Dan Evans' Task Force on Catastrophic Health Care Costs, issued in January, deals with some of these distressing facts;

Approximately 778,000 of our 3.5 million residents fall within the report's definition of medical indigency;

Upward of 50,000 Washington residents who potentially meet existing eligibility standards for Government medical care assistance programs are not receiving such assistance.

Current eligibility standards for medical care assistance are based on a maximum annual gross income for a family of four of roughly $5,000 and thus exclude many families—certainly those with incomes between $5,000–$6,000 annually—and beyond—which means poverty, given our horrendous inflationary economy.

Further, many governmental medical care assistance programs require families to divest themselves of virtually all their assets before becoming eligible for help.

As elsewhere, our news media reports anguishing case studies of ill persons unable to obtain health care, of families presented astronomical doctor and hospital bills. Small wonder that one often hears the bitter comment that our society provides socialism for the rich and capitalism for the poor.

Our State has a currently registered 8.9 percent unemployment rate, thus, many families have lost their job-related health insurance and are worried sick about their inability to pay outlandish medical bills. Why has not this Congress provided emergency benefits for the millions of unemployed workers and their families, as it has seen fit to do for the Vietnamese refugees we have taken in?

This year, Boeing, our largest employer, will have laid off 8,000 workers. In one of our agricultural areas, a group of physicians are opposing a Federal grant for a badly needed rural health care program. Ironically, the local originator and director of the grant is a practicing physician who has testified before this body on the unmet health needs of rural residents.

Some rural areas are unable to obtain the services of a doctor while our most populous county has a doctor-to-population ratio of 230 to 100,000—50 higher than the national average.

ENACTMENT OF HEALTH SECURITY IMPERATIVE

It is the deep conviction of our statewide alliance of concerned citizens from all walks of life that this society—the Earth's richest in both human and material resources can and must provide comprehensive health care as a right for all of its people.

That our Nation, on the eve of its bicentennial commemoration, has yet to secure this fundamental right for all its residents—as have other industrialized countries—is unconscionable.

The health care received by many Americans is unexcelled. Certainly our innovative democracy can devise a health care delivery system of equal excellence for all our people. Our study leads us to conclude that only the Health Security Program offers that rational possibility. None of the other pending proposals, as Leonard Woodcock clearly outlined in his testimony before this committee earlier, measures up to our needs and our expectations.

We call upon Congress to conclude its overlong deliberations and to act upon the best by far proposal before it—health security. Our ongoing devotion to the principles of life, liberty, and the pursuit of happiness requires your speedy action to insure health care is a right for all Americans.

Thank you, Mr. Rostenkowski.

Mr. ROSTENKOWSKI. Thank you, Mr. Mercer. Are there any comment that any panelists would like to make about each others' comments?

Are there any questions?

Mr. Cotter?

Mr. COTTER. Mr. Edwards, we have been sitting here for several weeks now and we have had a great deal of testimony to the effect that we are already spending well over $100 billion a year for health care and that a national health insurance program such as the Kennedy-Corman approach would only redistribute the costs. Actually I believe it would cost us more. Would you care to comment on that?

Mr. EDWARDS. Yes, I would.

I heard those figures, too, a couple of years ago. They were using the figure $70 billion.

Mr. COTTER. Anywhere up to $118 billion or $119 billion, whatever?

Mr. EDWARDS. First of all, it is a very interesting figure. When you talk about the increase in the amount of—amount that we as a society are spending on health care. That figure includes everything and all of the Federal budgets for health care including pollution control, building of buildings, staffing of offices with bureaucrats, printing forms, includes many things that have nothing to do with the actual providing of health care to people.

When we say that it is a redistribution, one of the things that I have always been kind of interested in is the way we talk about what society spends, what our society spends. Society doesn't spend anything. Society doesn't have money. People have money and only people can spend it.

We are talking about what actual living individuals have to pay and as a matter of fact in contradiction to what Mr. Pauley said, it is not the case that the Health Security Act would essentially cost the average citizen the same amount of money he now spends only it would be paid in taxes. It would cost about twice as much. That has been conceded even by some of its sponsors.

Now, I would also—if I may take the opportunity since you gave me the chance to talk again, there is one more point I would like to comment on that was made.

I have no quarrel with prepayment medical care. I believe that an individual physician should be able to provide care in any way he deems proper and individual patients should be able to buy that care in any way he deems proper.

It is a mistake, however, to offer the HMO concept, the prepayment concept, as a significant improvement in health care. The truth is the kind of Permanente experiments show in some clinics there is improvement, in others there is not. Dr. Sidney Garfield, one of the founders of Kaiser-Permanente wrote in an article in Scientific American that he was quite concerned by the fact that one of the changes when you had prepayment care as you would have with the Health Security Act is the great amount of utilization and the health system is flooded with people who are not only sick but who are well or who are well and worried about their health.

Mr. Pauley also commented on the fact that if we had—I believe what he said was essentially that if we now have high quality health care, then if we make this—create a system to this care is available to everybody then everybody will have high quality health care. But it doesn't work that way. When you have prepayment, when you have Government payment, you automatically have overutilization as they have found in Britain. You also find that the Government then is determining its priorities of spending because it is the Government that decides whether you are going to build a new hospital.

For example, I am not going to try to argue that between 1948 and 1962 when there were no new hospitals in England that that was because the British forgot how to mix mortar and build hospitals. It is because the Government then was determining that hospitals and health care were important, but they also had post offices and highways and other priorities that health care had to be weighed against. I think that the systems all throughout Europe have indicated a significant decrease in the quality of health care.

Mr. COTTER. Well, you stated that the Kennedy-Corman bill could cost twice as much as we are now spending. How do you arrive at that figure?

Mr. EDWARDS. I am basing that—not twice as much as what society is spending, I am basing that on figures from the Social Security Administration which found—this was a couple years ago—that the average family of four in this country was spending $550 a year for health care. But that the family of four's tax burden to support the Health Security Act would be $1,271.

Mr. COTTER. Thank you.

Mr. ROSTENKOWSKI. Mrs. Keys?

Mrs. KEYS. Yes; I would just like to ask Mr. Edwards a question or two.

Isn't it reasonable to say that essentially the dollars that go for paying the health bill of this country come out of individual citizens' pockets, period, whether they come out through the form of taxes, whether they come out through the form of premium payments to hospitalization plans, or whether they come directly out of pocket to a health care provider?

Mr. Edwards. Yes; well, the answer to that, of course, is yes, if; and the if, is if I need to go to the doctor, or if I need to go to the hospital, I pay. If I have 1 year or 2 years in which I do not need to go to the hospital or to a doctor, Idon't pay. But under the Health Security Act, I pay month after month, paycheck after paycheck whether I use the care or not.

Mrs. Keys. Mr. Edwards, 40 cents out of every dollar spent on health care now is spent by the Government throughh payments that have been collected in one way or another from individuals. All I am trying to point out is that I think somehow our dialog has escaped the recognition of the fact that, sure, we are paying for health care now and we are paying for it in many ways, and we are paying for it all the time, constantly, whether we use it or not. Yet, many of us do not have access to the kind of care that we need and have access to care that we have already paid for, supposedly, only if we happen to have some acute illness or happen to have a need to be hospitalized or even have to go to the hospital for basic routine preventive diagnostic care because that is the only way we can collect on what we have already paid. I think it is this that many of us are worried about, that our system that we have now has contributed toward the development of the most expensive delivery of health care and yet it has not encouraged and made it easy for people to use the kind of health care they need in just average maintenance of health for themselves and their families.

Mr. Edwards. I think that you have made a very good point.

So far as accessibility and availability in terms of distance, of course, and nearness at hand, there is no real problem in getting health care. In terms of insurance coverage, there is.

Now, as a point of fact, 89 percent, over that, of the American population that is not covered by medicare or medicaid does have private health insurance, but the problem comes with what that health insurance provides.

There is a great tendency of people to want first dollar coverage. First dollar coverage drives costs up; deductibles tend to keep those costs down.

I totally agree with you that the way some of the private insurance policies are written, do cause some of this problem that you are talking about.

Mrs. Keys. You know, it is interesting, I was just reading an article in the New England Journal of Medicine which was reviewing the Canadian experience and it found very affirmatively that a lot of these things had not happened and that the first dollar coverage of itself proved very sound and worthy because it eliminated all of the wasteful administrative costs of coinsurance and deductibles. It also found that there had been no outflow of doctors, rather than there is a better ratio of doctors to patients and some very interesting and positive assessments of that experience were made in this article and, of course, in many others I have read.

Mr. Edwards. If I may say so, Mrs. Keys, it is true in Canada they still have the doctors, but a lot of them are on strike.

Mrs. Keys. Thank you very much.

Mr. Rostenkowski. Thank you, gentlemen.

This will conclude our hearings today. The committee will adjourn until tomorrow morning at 9 o'clock.

[The following information was requested at p. 874:]

New York City
Department of Mental Health
and Mental Retardation Services,
New York, N.Y., December 5, 1975.

Hon. William R. Cotter,
U.S. House of Representatives,
Washington, D.C.

Dear Congressman Cotter: I greatly appreciate having had the opportunity to testify before you and the other members of the Committee at the National Health Insurance hearings last week.

With regard to the questions you raised about third-party reimbursement in the municipal hospitals, the gross budget for the twelve Health and Hospitals Corporation facilities which provide psychiatric services breaks down as follows:

HEALTH AND HOSPITALS CORPORATION MENTAL HEALTH BUDGET

[In millions of dollars]

	Gross	Collections	Net	State aid	Noncollectible
1974–75	105.0	52.4	52.6	26.7	21.9
1975–76	98.0	62.6	36.6	18.5	18.1

Approximately 60 percent of the patient population is Medicaid-eligible and 20 percent Medicare-eligible, while 8 percent of the patients pay their own hospital costs. Through improved collection procedures, this income has risen over the past year. By law, the State is required to reimburse the City for 50 percent of its net mental health expenditures, leaving the noncollectible costs to be picked up by the City. Because the Blue Cross-Blue Shield of Greater New York has refused to reimburse psychiatric services delivered at municipal hospitals, the City is faced with an annual loss of approximately $4.6 million, based upon the estimated 6 percent Blue Cross enrollees among the HHC facility patients. However, we are presently awaiting action on a bill before the NYS Assembly which will require all insurance plans to include mental health and alcoholism coverage under the auspices of any licensed and accredited hospital. The remainder of the noncollectible costs are incurred by emergency and other patients who cannot or will not pay their bills.

The net effect of a system which depends upon insurance providers and an inadequate public assistance program to provide the means for medical and psychiatric treatment is to deny those who cannot meet their expenses yet do not qualify for assistance, the working poor, the right to decent health care. As you can see, it is important that the Congress adopt a bill which ensures the delivery of health and mental health services through a single system of care. Without a national health program, not only the patients but the City and the nation must suffer from the effects of rising health costs.

I am glad to have had the chance to meet with you and to share my concerns about national health insurance, and hope that we can maintain a fruitful working relationship.

Sincerely,

June J. Christmas, M.D.,
Commissioner.

[Whereupon at 1:13 p.m., the hearing was adjourned, to reconvene at 9 a.m., Friday, November 14, 1975.]

NATIONAL HEALTH INSURANCE

FRIDAY, NOVEMBER 14, 1975

U.S. House of Representatives,
Subcommittee on Health,
Committee on Ways and Means,
Washington, D.C.

The subcommittee met at 9 a.m., pursuant to notice, in the committee hearing room, Longworth House Office Building, Hon. Dan Rostenkowski (chairman of the subcommittee) presiding.

Mr. Rostenkowski. The committee will come to order.

Will Drs. Johnson and Kelly, Mr. Chase, Dr. Clotworthy, Dr. Taylor, Dr. Chodoff, and Dr. Keisler with Mr. Dorken and Mr. Martin please take your seats.

Good morning, gentlemen. Welcome to the committee.

I would like to explain what the format is and the process that we have been following. We allow each of you 15 minutes to make your presentation. We will move from my left to right, your right to left, across the panel.

After you have concluded your presentations, we encourage an interchange between panelists and we allow that to happen for 45 minutes or so and then we will ask you questions. It doesn't necessarily mean that the 45 minutes will be all among yourselves. We try to participate in the discussion. So we thank you for coming in this morning and giving us the benefit of your thoughts.

A PANEL ON MENTAL HEALTH CONSISTING OF JAMES C. JOHNSON, M.D., AMERICAN PSYCHIATRIC ASSOCIATION, ACCOMPANIED BY LOUIS S. REED, PH. D., CONSULTANT; ALEX KELLY, M.D., PRESIDENT, WASHINGTON PSYCHIATRIC SOCIETY; IRVING H. CHASE, CHAIRMAN, PANEL ON NATIONAL HEALTH INSURANCE, NATIONAL ASSOCIATION FOR MENTAL HEALTH; WILLIAM B. CLOTWORTHY, M.D., AMERICAN ACADEMY OF CHILD PSYCHIATRY; ROBERT L. TAYLOR, M.D., STAFF PSYCHIATRIST, TEXAS DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION; PAUL CHODOFF, M.D., PROFESSOR OF PSYCHIATRY, GEORGETOWN UNIVERSITY MEDICAL SCHOOL; AND CHARLES A. KIESLER, PH. D., HERBERT DORKEN, PH. D., AND CLARENCE J. MARTIN, IN A JOINT PRESENTATION BY THE ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOLOGY, AMERICAN PSYCHOLOGICAL ASSOCIATION, AND COUNCIL FOR THE ADVANCEMENT OF THE PSYCHOLOGICAL PROFESSIONS AND SCIENCES

Mr. Rostenkowski. Dr. Kelly, if you would begin, the committee is ready to proceed.

STATEMENT OF ALEX KELLY, M.D.

SUMMARY

Because mental illness is the cause of many physical symptoms, because it is as crippling and as painful and as "real" as physical illness, we of the Washington Psychiatric Society advocate the following mental health benefits be included in any system of national health insurance:

1. Inpatient treatment for mental illness on exactly the same basis as physical illness, including partial hospitalization.
2. Chronic psychiatric conditions should be covered exactly as chronic physical conditions are.
3. Catastrophic coverage for mental illness ought to be identical to that provided for physical illness.
4. Outpatient treatment should be covered on the same basis as outpatient treatment for a physical condition.

Based on the latest statistics available to us from the National Institute of Mental Health and the Civil Service Commission, we believe such mental health benefits can be provided at a cost of between five percent and seven percent of the total benefit program, when such a benefit package is made available to the entire population. In the interest of cost containment and quality assurance, we believe such a program should have a careful peer review system built into it.

Dr. KELLY. I am Alex Kelly, president of the Washington Psychiatric Society, and I would like to say I appreciate the opportunity of being here and to give our position to this committee.

The Washington Psychiatric Society is a voluntary professional organization which represents 900 psychiatrists practicing in the greater Washington, metropolitan area. This statement represents the society's considered judgment on the question of mental health benefits and national health insurance.

The medical profession has long recognized that mental well-being is essential to the health of the whole person. Indeed, it is conservatively estimated that well over 50 percent of all patients seeking care for physical ailments are suffering from symptoms primarily caused by emotional problems. The Kaiser-Permanente prepaid group practice plans found, for example, that 68 percent of its doctor visits, made by 36 percent of its 1.3 million members, were for complaints for which no organic cause could be found. Thus, thousands of cases of asthma, hypertension, gastritis, ulcers, migraine headaches, low back pain, and amenorrhea and other physical disorders are never really cured because the true cause, emotional illness, remains untreated. The Goldberg study of the Group Health Association of Washington, which I will discuss later in more detail, showed that GHA actually saved money by providing mental health services, which lessened the demand for other medical services.

Because mental illness is the cause of many physical symptoms, because it is as crippling and as painful and as "real" as physical illnesses, the medical profession recognizes emotional disorders as medical disorders and coverage for mental disorders under national health insurance should be equal to that provided for physical disorders.

We of the Washington Psychiatric Society believe, recommend, and advocate the following specific benefits for mental health care should be included in national health insurance:

1. Inpatient treatment for mental illness should be provided exactly as for physical illness. Mental illness is every bit as painful and crippling as polio is crippling.

2. Chronic psychiatric conditions could be covered as are chronic physical conditions such as heart disease or renal problems. Psychosis is as devastating to the human personality as multiple sclerosis is to the body.

3. Catastrophic coverage for mental illness ought to be identical to that provided for any other illness. A teenager intent on suicide is as catastrophic to himself and family as a case of bone cancer or leukema.

4. Long-term outpatient psychotherpy should be covered by national health insurance on the same basis as any physical conditions that require long-term treatment. Chemotherapy or radiation treatment would not be denied a post-operative cancer patient; neither should long-term psychotherapy be denied a once-suicidal neurotic or others suffering from severe emotional disorders.

Comprehensive care should include certain essential elements, including every individual's access as needed, without financial, geographic, or other barriers, to the whole spectrum of health services—preventive, advisory, rehabilitative, and long-term care as well as diagnostic and therapeutic measures. Active treatment of mental disorders should be covered in physicians' offices, outpatient clinics, general hospitals, psychiatric hospitals, partial hospitalization, community health centers, and health maintenance organization—wherever care is required.

NATION'S CHILDREN

The Joint Committee on the Mental Health of Children (a commission established by the Senate and the House of Representatives) stated in 1970 that there are 10 million young people (under 25) in need of help from mental health workers. Slightly more than one-tenth of the children who needed services were getting psychiatric help. An additional 1 million children were diagnosed as needing psychiatric help, but none was available to them either because of lack of money or the maldistribution of mental health professionals. The remaining almost 8 million children were receiving no help at all.

The children who need help and are not getting it will become the school dropouts, the drug users, and the juvenile delinquents of today and nonproductive adults of the future. Without treatment disturbed children will grow to adulthood severely crippled in their ability to cope with work and with normal family life. Our Nation loses twice when it neglects these children: once in the loss of tremendous human potential; second, in the cost these children will ultimately be to society.

THE ECONOMICS OF PROVIDING MENTAL HEALTH BENEFITS

Unfulfilled adult lives also cost us twice—once in the loss of human resources, in the apathetic, disturbed and violent souls in our midst, and again in the loss of productivity to our society, and the economic costs of dependency. Emotionally disturbed employees make bad employees; emotionally stable employees increase productivity.

We recognize that one of the main reasons mental health benefits have been either limited or excluded from some plans for national health insurance is due to the urgent concern for cost containment.

As taxpayers, as well as doctors, we share this concern, although we believe this concern is excessive and based not on fact but on prejudice. But current concepts of mental health care are based on substantial evidence that the patient has a better chance to recover without significant loss of functioning capacity and to avoid hospitalization (which is much more costly than outpatient treatment) if he receives adequate outpatient treatment at an early stage in his illness. Too stringent a limit on outpatient care will result ultimately in increased costly hospital treatment, to say nothing of the increased cost in human suffering.

Recently completed research further demonstrates that in Canada with equal coverage for mental illness, the percentage of total medical benefits going for mental illness care, about 5 percent or lower, seemed a most acceptable amount.

In the Blue Cross-Blue Shield Federal Employees Health Benefit Plan, with a broad comprehensive coverage for mental illness and covering several million Federal employees, the costs of mental illness have not increased materially since 1971. About 7.25 percent of medical costs go for mental health benefits. It can thus be projected that comprehensive diagnostic and treatment services provided by qualified mental health professionals would comprise only 5 to 7 percent of national health insurance costs.

As I stated earlier, providing mental health benefits reduces the cost of physical health benefits. Dr. Irving D. Goldberg of the National Institute of Mental Health in studying the Group Health Association of Washington found that patients treated by mental health providers reduced the nonpsychiatric physicians' usage within the group by 30.7 percent in the year after referral for mental health care. Use of laboratory and X-ray services declined by 29.8 percent. When the cost savings were compared to the direct cost of providing care, GHA saved money by providing mental health services.

Five percent of a large group of union industry health plans provide greater benefits for mental illness than for physical illness. In other words, they had no outpatient benefits for general conditions, but they did have outpatient psychiatric benefits. If, therefore, national health insurance is enacted without comprehensive mental health benefits, large groups of workers employed in our major industries would have important benefits, which they are now receiving, taken away from them.

MODALITY OF TREATMENT

There is no one mental illness, no single cause, no "either it is organic or not." In some mental illnesses there are demonstrable changes in the neuroanatomy or neurophysiology; in the majority, there are not. These are the so-called functional disorders in which some combination of the intellectual, social and emotional function is defective often due to underlying maldevelopment of the personality structure, which in turn is related to childhood maladjustments.

It is our firm belief as physicians that the patient should always be offered that treatment which not only effectively treats the present symptoms, but which does what is possible to remove or ameliorate the underlying cause. The concept of latent disease is widely recognized in other fields of medicine as well as in psychiatry.

Long-term intensive psychotherapy, including psychoanalysis, is a proven method of treatment which is often the only treatment which can effect change in underlying or latent psychopathology which must be treated if the patient is to experience lasting relief from difficulty. There are, of course, sometimes differences of opinion among psychiatrists as to the best treatment on individual cases the same as there are differences of opinion among other physicians on the best method of treatment for certain physical disorders. National health insurance should provide for coverage of all treatments that are recognized by the profession as valid treatment. Inasmuch as such treatment is sometimes time-consuming and expensive, we recommend that national health insurance provide for proper review of the nature of the problem and the treatment indications by a properly constituted group of peers expert in the treatment considered. Any peer review must, of course, provide for safeguards of the patient's inviolable right to privacy.

The Washington Psychiatric Society has put into effect what we consider a workable, effective peer review mechanism taking into account both humanitarian and cost control issues. Dr. Paul Chodoff, who is a consultant to your committee and on this panel today, will discuss this in more detail.

As physicians first and psychiatrists second we are concerned with the totality of a given patient's ability to function as a productive citizen. We are concerned with disorders of thinking, of feeling, interpersonal relationship and bodily functions that prohibit a person from achieving his full capacities to work and live productively. Our goal is to correct dysfunctioning minds to allow a more productive and satisfying life. When one considers that effective treatment provides a useful citizen returned to society and when one views the dollar costs realistically, the costs are slight compared to the productiveness regained by the individual and society at large.

Thank you.

Mr. Rostenkowski. Thank you, Dr. Kelly.

Dr. Johnson?

STATEMENT OF JAMES C. JOHNSON, M.D.

Dr. Johnson. Mr. Chairman and members of this committee. I am here to testify in behalf of the American Psychiatric Association, which represents 23,000 psychiatrists in the United States and a much larger number of patients.

My name is James C. Johnson. I am deputy commissioner of mental health for treatment services of the State of Connecticut. I am past speaker of the Assembly of District Branches and chairman of the Council on Mental Health Services of the American Psychiatric Association.

With me is Louis S. Reed, Ph. D., consultant in health economics of the American Psychiatric Association. My remarks will be brief so that you may have time to ask Dr. Reed any questions you may have on utilization and costs of mental health benefits in health insurance plans. We request that his most recent study, "Coverage and Utilization of Care for Mental Conditions Under Health Insurance—Various Studies, 1973–1974," be included in the record.

Mr. Rostenkowski. Dr. Johnson, we will put this on file with the committee.

Dr. Johnson. Thank you, sir.

Mental and emotional illness is the Nation's number one health problem.

Mental and emotional illness is the Nation's No. 1 health problem.

The position of the American Psychiatric Association is that psychiatric care is an essential part of adequate health care and must be provided to the same extent and at the same level as other types of health care. Adequate safeguards such as peer review and utilization review to insure both quality and appropriateness of care must be part of any proposal for national health insurance.

This association also believes that psychiatric care provided under national health insurance should be limited to active treatment of illness or disability. Another essential element of psychiatric coverage is protection for the rights of patients to privacy, confidentiality, and free choice of source of treatment.

We believe that the present pluralistic system of health care delivery must not be altered to force patients into any specific type of treatment setting. A number of congressional proposals for national health insurance contain a higher level of mental health benefits in organized settings than for other types of settings. However, there is no conclusive evidence to indicate either lower cost or superior quality of service or delivery in the public sector. Moreover, there is great regional variability in the availability of specific types of resources for the treatment of mental illness. Therefore, the approach of more extensive coverage in organized settings is premature.

Within a relatively short time the treatment of mental and emotional illness has made great strides. These advances have been accomplished in the areas of the evolution of new treatments, pharmacologic and psychologic, discoveries and developments in the basic sciences relating to brain function, neurology, drug action on brain loci, and mental illness prophylaxis. The medical specialty of psychiatry has had particular success in the treatment of depressive disorders through the combination of drug and psychologic therapy. The development of group, family, and behavior therapies have also added measurably to the armamentarium against mental and emotional illness.

Of the approximately 20 million Americans who suffer from mental and emotional illness, less than one-third receive at least some minimal type of intervention, while only about half of these receive some type of psychiatric treatment. Fourteen of the 20 million go totally untreated.

Treatment for mentally ill children, the highest area of payoff in preventive services has a dismal record. A survey conducted in New York reports that only one out of 160 children between the ages of 2 and 18 requiring care is being treated.

Only 20 percent of 3 million people over 65 who suffer from mental illness receive any treatment, and the aged account for 22 percent of the patient population in mental hospitals.[1] Nevertheless, the trend in coverage of mental and emotional illness has been gaining rapid momentum, especially in health insurance plans of large employers and/or unions. Of 148 such plans selected by the U.S. Bureau of Labor Statistics, representing a cross-section of American industries, and included in the study of Dr. Reed, 68 percent have the same inpatient benefits for mental illness as for other conditions, and 41 percent have the same degree of outpatient care. Five percent (all of which were negotiated by the United Auto Workers) provided more extensive benefits for mental than for general conditions. These plans had no significant outpatient benefits for general conditions, but did have outpatient psychiatric benefits.

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[1] Division of Biometry; Alcohol, Drug Abuse and Mental Health Administration.

States have also been increasingly frequently passing legislation mandating mental health benefits in private health insurance policies, and some States now require substantial inpatient and outpatient coverage. This strong trend toward universal coverage of mental illness is taking place because it makes good sense, from an economic as well as humanitarian perspective.

More than half the patients who go to physicians with physical symptoms are suffering from a component of mental or emotional illness. By providing psychiatric benefits, their conditions will be fully treated. This, in turn, will decrease utilization of general medical services, and extensive testing such as laboratory, X-ray, and other procedures. This fact has been demonstrated in a study of the Kaiser Foundation Hospital and the Permanente Medical Group of California, and in the Goldberg-Krantaz-Locke study with the Group Health Association of Washington, D.C.

The National Institute of Mental Health has estimated that there are 7.4 million people who suffer from psychophysiologic, autonomic, and visceral disorders that require a combination of somatic and physiologic treatment. 1.8 million suffer from psychoses and require extensive treatment in order to maintain some level of productivity, or to prevent hospitalization; 10.6 million suffer from neuroses varying in degree and requiring treatment to maintain function. Large numbers of people also suffer from alcoholism and drug abuse requiring treatment in order to recover functional ability. These represent a sample of the categories of mentally disabled or impaired people who require treatment.

Data developed from existing utilization and costs of mental illness coverage in insurance plans and in private practice studies amply demonstrate the economic feasibility of such coverage.

We have seen from the Blue Cross and Blue Shield Plan for Federal Employees, which covered an average of nearly 5.6 million persons during 1974, a plateauing of percentage of expenditures for mental illness from 1971 to 1973. From 1971 to 1972 there was an increase of .1 percent for mental illness benefits (from 7.0 to 7.1 percent), and from 1972 to 1973 there was an increase of .2 percent (to 7.3 percent) in benefits. While there did occur an increase in utilization of mental health benefits during the initial period of the plan, we have seen a leveling off in mental health services utilization to a fairly fixed percentage.

There should exist in any national health insurance an equitable distribution of mental health benefits between inpatient and outpatient services. The absence of adequate outpatient services will result in greater and more expensive utilization of inpatient services. The cause is that mentally ill patients amenable to management through outpatient psychotherapy would not receive early ambulatory care and their potentially exacerbated conditions would, in many cases, eventually require hospitalization.

We believe that many hospitalized patients, including those with chronic conditions, could reside in the community as productive citizens with the support of a maintenance program of outpatient psychiatric services. There are others who require more intensive, but shorter term, therapy in order to effect desired results.

An effective system of peer review will determine the necessity of extensions of treatment periods. Psychiatry is making excellent progress in peer review around the country. For example, the Washington Psychiatric Society has a relatively large-scale effort mounted in peer review. Paul Chodoff, M.D., a member of this subcommittee's advisory council, is chairman of the Washington Psychiatric Society's Peer Review Committee.

Finally, Dr. Reed's study reports the Canadian experience in which care must be provided for mental and nervous disorders on the same basis as for all other conditions. There can be no dollar limits or exclusions except on grounds that the services are not medically required. The number of psychiatric services constituted a relatively small proportion of the number of all services, ranging from 1 to 4.5 percent. The payments for psychiatric services ranged from 1.3 to 5.4 percent of the total of all medical services.

Our association expects to be able to release its final refined position on national health insurance very shortly. In the meantime, we wish to report to this subcommittee our impression that individual Members of Congress generally favor a nondiscriminatory coverage of those suffering from mental and emotional illness in any proposal for national health insurance.

We hope that we may continue to have close communication with this committee so that every ramification of this vital issue affecting millions of Americans will receive the fullest and most deliberate consideration.

Thank you, Mr. Chairman.

[Attachment to the prepared statement follows:]

ATTACHMENT TO THE PREPARED STATEMENT OF THE AMERICAN PSYCHIATRIC ASSOCIATION

PRINCIPLES OF MENTAL HEALTH COVERAGE UNDER NATIONAL HEALTH INSURANCE

The American Psychiatric Association supports the fundamental right of the American people to adequate health care, which includes mental health care. We therefore advocate the following principles, which we believe will serve as a foundation to achieve this under national health insurance.

1. The consumer should have freedom of choice of the locus and modality of care. A national health insurance law should not discriminate for or against any one form of delivery.

2. A pluralistic service delivery system, including both the public and private sectors, should be available to meet the varied needs of persons with emotional disorders. This delivery system should be coordinated in such a way as to assure that current inequities are minimized and eventually eliminated.

3. Provision of benefits should be based on the need for services and on the appropriateness of a service to meet that need. Services should be limited to

diagnosis and treatment.[1] The full range of treatment modalities, including alternatives to hospitalization, should be available to meet the appropriate needs of the consumer. To encourage early diagnosis and treatment, co-payment and/or deductibles, if required, should apply only after the initial diagnostic evaluation and crisis intervention phases of care are completed. Coverage for psychotropic medications should be provided without deductible or co-payments. Generic forms of drugs should be specified except where such forms are not available.

4. A peer review system for all modalities and types of mental health care is imperative to assure that the appropriate quantity and quality of service is delivered. This system should be responsive to the consumer, to the service provider, and to the insurer. Control of utilization will be achieved by substantive peer review of all modalities of care. This will contribute to cost containment as well as the control of abuses and inappropriate uses of services. The cost of peer review must be included as a part of administrative overhead in any national health insurance program. (This approach is already being employed by CHAMPUS and the Federal Employees Blue Cross-Blue Shield Benefit Program.)

5. Certification, accreditation, and licensing should be the primary basis for coverage of individual providers of care as well as for mental health facilities.

6. Incentives should be provided to assure that more service providers and facilities are available to populations which are currently underserved, i.e., children, rural and inner-city dwellers, minorities, and the aged.

7. If a health and mental health strategy under national health insurance is to be successful, the insurance program should provide for continued support of quality assurance, i.e., development and monitoring of performance criteria under the Joint Commission on Accreditation of Hospitals, mental health research, appropriate manpower development and production, evaluation, primary prevention strategies, and long-term care.

8. Adequate provision must be made to assure that confidentiality is maintained under any national health insurance legislation.

9. There should be no discrimination by providers based on age, sex, handicap, race, creed, or social or economic circumstances.

DATA DEMONSTRATING ECONOMIC FEASIBILITY OF COVERING MENTAL ILLNESS

An increasing body of evidence documents the feasibility of providing adequate coverage of mental health services under insurance.

The prime locus of mental health care has shifted from state mental hospitals to the community; and short-term care, often in an outpatient setting, is now the rule rather than the exception. The success of this change is reflected in the data indicating the feasibility of covering mental health services under insurance.

The most detailed data available on a large private insurance plan with broad mental health benefits is that for the high option of the Blue Cross/Blue Shield plan for federal employees, which covers nearly 4.7 million persons. Full coverage for 365 days per admission is provided for hospital care of mental conditions in general hospitals and in mental hospitals that are member hospitals of Blue Cross plans. Physicians' in-hospital charges are also covered in full. Under the supplemental benefits (which also supply to non-member psychiatric hospitals) the plan pays 80 percent of physicians' charges for out-of-hospital care, subject to a deductible of $100 per person per year. The low option (about 600,000 enrollees) covers only 30 days of in-hospital care and 75 percent of physicians' charges under supplemental benefits, subject to a $150 deductible.

A recent study by Dr. Louis Reed[1a] indicates that utilization of care for mental disorders under the high option of this plan was virtually the same in 1973 as in 1972 and that the upward trend in utilization that had characterized the plan virtually since its beginning in 1960 seemed to have ended. Thus in 1973, benefits for mental disorders (high option) constituted 7.3 percent of benefits for all conditions, compared with 7.1 percent in 1972. Basic hospital benefits for mental disorders were 5.8 percent of benefits for all conditions, compared with 5.9 percent in 1972. Under the low option (which enrolls only about 11 percent of all those enrolled in this plan) the percentage of total benefits going for mental disorders showed a moderate increase. Following is a tabulation of the percent of total benefit payments going for treatment of mental and nervous conditions under both options of the Federal Employees Blue Cross and Blue Shield Plan since its inception.

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[1] Explanation of "treatment." (*Psychiatric Utilization Review: Principles and Objectives*, 1968) "A physician is primarily concerned with rendering treatment—directly or in collaboration with other members of the treatment team—in an appropriate and responsible fashion. He is not primarily concerned with whether someone will judge this treatment effort to be active, intensive, semi-active, rehabilitative, or preventive. In fact, the physician would say that the word 'active' is somewhat redundant when modifying the word 'treatment', since treatment by definition implies that he and his agents are doing something to meet the patient's . . . needs."

[1a] L. S. Reed: Utilization of Care for Mental Disorders Under the Blue Cross and Blue Shield Plan for Federal Employees, 1973. American Psychiatric Association, Washington, D.C., 1975 (processed).

	Benefits paid for mental disorders	Total benefits paid	Percent
1960–65	$40.2	$1,040.4	3.9
1966	13.2	277.2	4.8
1967	18.1	336.8	5.4
1968	24.8	405.0	6.1
1969	30.4	480.9	6.3
1970	41.1	601.9	6.8
1971	49.1	698.9	7.0
1972	54.3	760.4	7.1
1973	61.6	848.2	7.3

Source: Office of the Actuary, U.S. Civil Service Commission.

The inpatient data from the Blue Cross/Blue Shield federal employees plan also contain information as to the percent of persons receiving inpatient care under basic benefits who are released within given time periods. Data are available for the U.S. as a whole and for three areas: the District of Columbia, Maryland, and Virginia; Ohio; and California. The data revealed that the 80 percent of persons receiving inpatient care for nervous and mental disorders who were released within 30 days accounted for 45 percent of the total charges; the 89 percent who were released within 45 days accounted for 62 percent of the charges; the 97 percent released within 90 days accounted for 84 percent of the charges; the 99 percent released within 120 days accounted for 91 percent of the charges: and the remaining 1 percent with more than 120 days accounted for 9 percent of the charges. (See Table 2 for additional details.)

In regard to outpatient care, newly released data show that in 1973[2] there were 29,541 persons out of the covered population of 4,675,000 under this plan who had claims for physicians' care of mental disorders under supplemental benefits. These persons constituted 6.3 per 1,000 of the covered population or 0.6 of one percent. Total covered charges amounted to $22.4 million, or $4.78 per covered person. Of all persons incurring mental charges, 62.2 percent had charges of less than $400; their charges amounted to 15.3 percent of the total. Another 28.5 percent had charges of between $500 and $1,999; their charges amounted to 38.3 percent of the total. Another 7.2 percent had charges of between $2,000 and $5,000 during the year; their charges amounted to 29.1 percent of the total. Finally, 2 percent of the persons had charges of over $5,000, amounting to 17.4 percent of the total. The average charge per person with charges was $757; the median was $384.

Data are also available for calendar year 1972 from the Civilian Health and Medical Program for the Uniformed Services (CHAMPUS), which has an essentially unlimited mental health benefit. The average cost per user beneficiary of outpatient mental services was $478; although some patients had many visits, the majority were handled within 15 visits. The average cost per user beneficiary of inpatient services was $2,258; this relatively high cost is affected by the number of child and adolescent beneficiaries receiving long-term care in residential treatment facilities.[3]

Recent data are also available from prepaid group practice plans. One of these is the Harvard Community Health Plan, serving some 34,000 members in the Boston area who are enrolled primarily through their employment. The mental health coverage is for problems of recent onset judged to be amenable to improvement through relatively brief treatment. Outpatient care in the plan's health centers includes one or two evaluation visits, 15 subsequent visits at $1 per visit, plus additional visits at $10 a visit. Inpatient care includes 45 full days or 90 partial days, all at full coverage. Data for 1973 indicated that 5 percent of the outpatient visits per year were for mental health services (.21 visits out of a total of 4.3 visits for all causes). Estimated cost for this benefit was $10.50 per member per year, not including administrative overhead. In regard to hospitalization, the number of hospital admissions with a psychiatric diagnosis was 1.6 per 1,000 members per year; the number of hospital days was 17.2 per 1,000 members per year; and the average length of stay for a psychiatric admission was 10.8 days. The cost per member per year for this benefit was $1.50. Thus the total cost for this psychiatric benefit was $12 per member per year, or $1 a month.[4]

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[2] L. S. Reed: unpublished data prepared for the American Psychiatric Association, 1975, Washington, D.C.

[3] *Insurance for Mental Health: Trends in the Delivery and Financing of Mental Illness Services in the United States* (draft document). Report of the Work Group on Health Insurance, National Institute of Mental Health, Rockville, Md., November 1974.

Another mental health benefit program that has been extensively studied is that of the United Auto Workers, which provides up to $400 a person a year in outpatient coverage plus up to 45 days of inpatient care. This plan is unique in regard to its copayment arrangement. There are no deductibles, and if the patient receives his care from an accredited group facility there is no copayment; if he gets his care from a private physician under a fee-for-service arrangement he pays nothing for the first five visits and an increasing percentage thereafter up to the $400 limit. The utilization experience of UAW members in Baltimore, Md. (18,799 in 1967, 24,000 in 1970) was studied over the four-year period 1967–1970, during which 580 different individuals, or 2.7 percent of the mean population at risk, utilized the mental health benefits.[5] The cost per enrollee increased from $2.71 in 1967 to $5.41 in 1970—still well under 50 cents per enrollee per month.

Of the 580 patients, 228 presented themselves initially to the Johns Hopkins Labor Union Clinic, which was approved by the UAW to provide service under this program, and 353 presented themselevs to some portion of the fee-for-service system. The hospitalization rate was much higher among the patients seen through fee-for-service financing; 52 percent of the patients seen through that method were hospitalized at some point compared with 4 percent of the patients using the Labor Union Clinic. (This low rate of hospitalization is characteristic of prepaid group practice programs.)

The researchers who studied utilization under the Baltimore UAW program made an interesting observation about the value of the dual choice that was available to the population studied. They note: "Even the most meaningful system of community control is no substitute for the individual patient's vote with his feet to go elsewhere when he is dissatisfied. The UAW contract provides for such free choice even where accredited groups are established. No 'charity clinic' atmosphere could long exist in union mental health programs without the patients soon shifting to private practitioners." [5]

Information was recently obtained by Dr. Louis Reed on utilization under the Canadian federal-provincial programs of hospital and medical insurance.[6] This program is of particular interest because, unlike most private health insurance plans in the United States, it covers care for mental conditions on the same basis as other conditions, and the coverage is complete—all needed care is provided. (It should be noted however, that apart from the insurance program, all provinces maintain mental hospitals and clinics in which services are provided essentially free to all residents.)

Under the hospital insurance program (in existence since 1966) the federal government pays approximately 50 percent of the cost of approved provincial programs. To qualify for federal cost sharing, a provincial program must provide complete care in general hospitals to all eligible residents on uniform terms and conditions. There can be no limit on length of stay. In some provinces there is some cost sharing by the patient. In 1971 hospital separations with a diagnosis of mental illness comprised 3.7 percent of all separations and patient days for mental illness were 5.7 percent of days for all conditions.

Canada's medical service insurance program is more recent than the hospital program; federal financial contributions to participating provinces became available in 1968 and all provinces were participating by 1971. The provincial programs must cover all medically necessary services by a physician. Private practitioners are paid according to a fee schedule negotiated with the provincial medical society; some other doctors are paid by capitation or salary arrangements. In 1971, 1972, or 1973 (the year varied with the province), payments for psychiatric services ranged from 43 cents to $3.15 per covered person and constituted 1.4 to 5.4 percent of total payments for all medical services.

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[4] R. L. Biblo, personal communication, October 3, 1974.

[5] H. R. Spiro, G. M. Crocetti, and I. Siassi: "Fee for Service Insurance versus Cost Financing: Impact on Mental Health Care Systems," *American Journal of Public Health* 65: 139–143, February, 1975.

[6] L. S. Reed: Utilization of Care for Mental Conditions Under Canadian Governmental Hospital and Medical Insurance Programs. American Psychiatric Association, 1975 (processed), Washington, D.C.

Another recent study[7] also by Dr. Reed, gives us for the first time an approximation of the extent to which employees in a cross section of American industry are covered for mental illness under their employee health benefit plans. Dr. Reed was given access to the data summarized in the U.S. Department of Labor's most recent *Digest of Selected Health and Insurance Plans*, which has been published intermittently for many years by the Bureau of Labor Statistics. The digest provides information on the plans of 140–150 large employers and/or unions in major industries, selected so as to constitute a rough cross section of American industry and including many industrial plants such as General Motors, American Telephone and Telegraph, General Electric, U.S. Steel, International Business Machines, and Goodyear.

Of the 148 plans studied, 68 percent (as of August 1974) provided the same hospital benefits for mental conditions as for other conditions; the remaining 32 percent had reduced benefits. Forty-one percent of the plans provided the same outpatient (office) care of mental as of other conditions, 45 percent had reduced benefits for mental conditions, 8 percent had no outpatient coverage for either mental or other conditions, and 5 percent (all of them plans negotiated by the United Auto Workers) provided greater benefits for mental than for other conditions—that is, they had no outpatient benefits for general conditions but did have an outpatient psychiatric benefit.

The APA book *Health Insurance and Psychiatric Care: Utilization and Cost*[8] contains data on costs of inpatient and outpatient care for a wide variety of other insurance plans; selected data from that book are shown in Tables 4 and 5.

PEER REVIEW

There have been promising recent developments in peer review

Peer review is a process through which expert clinical judgment determines the appropriateness of the care rendered to patients. APA's interest in this area dates back at least to 1967, when a study of in-hospital utilization review was undertaken and published in the form of a pamphlet titled *Psychiatric Utilization Review: Principles and Objectives.*[9] In 1971 an APA Task Force on Peer Review was established; it mapped out a collaborative program with both national and local components. Each APA district branch (now 70 in number) proceeded to develop peer review committees and to formulate plans for local peer review efforts either on its own or in conjunction with local medical societies. In 1973 an Ad Hoc Committee on Professional Standards Review Organizations was appointed to participate with AMA in a collaborative effort by 30 national specialty societies, each agreeing to design trial criteria sets which could be used in the clinical review of its diagnostic categories believed to account for 75 percent of hospital admissions under the purview of the respective specialty.

APA's *Model Criteria Sets* were published in 1974 and distributed to all district branches—not to serve as national or official guidelines for review but as a stimulus to the local component. A new Task Force on Peer Review, which was set up in 1974 and replaced the former ad hoc committee, is collaborating with district branches in revising and expanding the inpatient criteria sets and formulating initial approaches to review methods for ambulatory care.

A special section in the December 1974 issue[10] of the *Ameriacn Journal of Psychiatry* contained seven articles on PSROs and other peer review mechanisms. For example, the article by Donald E. Newman and Lorraine L. Luft describes a peer review system that has been in effect at the Peninsula Hospital Community Mental Health Center in Burlingame, California, for three and a half years. Set up as a mechanism to control the allocation of limited funds for treatment provided on a fee-for-service basis by 90 practicing psychiatrists, psychologists, and social workers, the peer review system has been able to meet clinical needs within existing financial constraints. More than 1,000 inpatient, partial care, and outpatient cases have been reviewed by means of a multidisciplinary clinical case conference format. The section also contains an editorial on peer review by APA President John P. Spiegel and Deputy Medical Director Donald W. Hammersley. They noted that some of the articles in the journal suggested approaches that have proved useful in some settings and could be adapted to other settings. But, they added, "these islands of adequacy must grow to an effective national network, and the network must be of uniformly high quality. Obviously this will take an increasing commitment from the membership—in time, in energy, in dedication. We know of nothing as difficult and yet as important."

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[7] L. S. Reed: Comparison of Benefits for General and Mental Conditions Under Employee Health Benefit Plans, 1974, American Psychiatric Association, 1975 (processed), Washington, D.C.

[8] L. S. Reed, E. S. Myers, and P. L. Scheidemandel: *Health Insurance and Psychiatric Care: Utilization and Cost.* American Psychiatric Association, Washington, D.C., 1972.

[9] *Psychiatric Utilization Review: Principles and Objectives.* American Psychiatric Association, 1968, Washington, D.C.

[10] Special Section: PSRO and other Peer Review Mechanisms, *American Journal of Psychiatry* 131:354—1386, December 1974.

In pursuit of the goal stated by Drs. Spiegel and Hammersley, APA convened a meeting of its Commission on Standards of Practice and Third-Party Payment February 28–March 1, 1975 in Washington, D.C. to hear reports of peer review representatives from six APA district branches. Some of the peer reveiw activities described have been going on for as long as five years. The programs were those in Chicago, New York City, Boston, New Orleans, Los Angeles, and Washington, D.C. Representatives of third-party payers were also present, including Blue Cross, Blue Shield, Aetna, and CHAMPUS; several of these expressed enthusiasm for the prgorams that were described. The meeting also heard a report of the pilot project being undertaken by the National Institute of Mental Health and the Civil Service Commission (with APA cooperation) to set up model peer review programs in two or three areas of the country.

Psychiatrists have been cooperating in a review program established late in 1974 to assure that an appropriate level of treatment is being provided in residential treatment centers for children and adolescents covered under CHAMPUS. Dane Prugh, M.D., of Denver, a prominent child psychiatrist, is chairman of the Select Committee on Psychiatric Care and Evaluation, which is coordinating the activities of several professional case review teams which are assessing whether continued treatment in the residential treatment centers is appropriate; later the committee will make recommendations to the Department of Defense (which administers CHAMPUS) on standards for quality care.

Related to peer review is the entire area of patient care evaluation, which has received increasing attention in the past few years. For example, a research team at the Yale Institute for Social and Policy Studies has developed criteria of appropriateness, adequacy, and effectiveness of psychiatric care. These criteria are designed to provide guidelines for admission to treatment services—"to partition patients into clinically meaningful groups that receive similar patterns of care," standards for assuring that the treatment process unfolds in a rational and systematic matter, including alternatives to an intervention that has proved unsuccessful, and measures of success that can be used to establish readiness for discharge.[11] Muller and Schoenberg[12] observe that this movement "should help resolve the issue of subjectivity and unpredictability of case management often raised by insurance carriers."

Most present insurance plans provide incentives for inpatient care rather than for other forms of care that would be more appropriate and less expensive.

Part of the problem concerning the preferential coverage of inpatient care is not unique to mental health services; the Social Security Administration estimated in 1969 that 157 million persons in the U.S.—78 percent of the civilian population—had some private health insurance coverage of hospital care but only 86 million—43 percent of the population—had some coverage for physicians' outpatient visits; both these figures apply to all illness.

In regard to mental illness, there is substantial discrimination against the mentally ill in regard to hospital coverage, this has proved to be less burdensome (at least for many patients) than formerly because of the decline in the average number of hospital days per admission. However, most mental health professionals believe that many patients with mental or emotional disturbances would not have to be hospitalized at all if their difficulties were treated at an early stage on an outpatient basis, or if partial hospitalization were available.

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[11] G. L. Tischler, D. C. Reidel: *A Criterion Approach to Patient Care Evaluation.* New Haven, Health Services Research Program, Yale University Institution for Social and Policy Studies, 1973, pp. 3. 5. 7.

[12] C. Muller and M. Schoenberg: "Insurance for Mental Health: A Viewpoint on its Scope," *Archives of General Psychiatry* 31: 871–878, December 1974.

It was reasoning such as this that encouraged the United Auto Workers, in its negotiation with the automobile industry, to ask for an outpatient benefit for any other kind of illness. Unfortunately this example has not been followed by most other unions and large employers, with the result that outpatient coverage of mental illness is less available to meet a patient's need than is inpatient coverage. The problem is exacerbated by the stigma against seeking help for a mental illness that is still prevalent, even though there has been a shift in public attitudes in recent years.

Medicare is an example of a large insurance program that gives preferential treatment for inpatient care of mental illness. If treatment under Medicare takes place in a general hospital there is no difference between the benefit for mental illness than in the benefit for other illness (although there is a 190-day lifetime limit for care in a psychiatric hospital). For out-patient treatment the benefit is miniscule: a maximum payment of $250 or 50 percent of reasonable charges, whichever is less, after the $50 deductible is met.

There are also severe restrictions on partial hospitalization under all types of insurance. For example, of the 13 pairs of Blue Cross and Blue Shield plans recently studied by Dr. Louis Reed[13] only three covered partial hospitalization in 1974. APA's earlier study[8] noted that in 1969, 15 of the 76 Blue Cross plans provided payment for day care under the most comprehensive certificate and seven under the most widely held certificate. Night care was covered to almost the same extent.

NUMBER OF VISITS OF ALL PATIENTS IN PAST 12 MO BY LENGTH OF TIME SINCE PATIENTS WERE FIRST SEEN

PRIVATE OFFICE PSYCHIATRISTS

	Patients 1st seen a year or more before		Patients 1st seen less than a year before		Date patients 1st seen unknown number	Total	
Number of visits in past 12 mo	Number	Cumulative percent	Number	Cumulative percent		Number	Cumulative percent
Less than 10	267	12	791	44	11	1,069	26
10 to 19	250	24	352	64	12	614	42
20 to 29	205	33	226	76	10	441	52
30 to 39	137	39	136	84	4	277	59
40 to 49	367	56	87	89	8	462	71
50 to 59	142	62	51	91	2	195	75
60 to 69	46	65	31	93	1	78	77
70 to 79	42	66	25	95	0	67	79
80 to 89	78	70	25	96	3	106	82
90 to 99	137	76	14	97	3	154	85
100 to 109	118	82	17	98	0	135	89
110 to 119	10	82	5	98	0	15	89
120 to 129	54	85	4	98	1	59	91
130 to 139	44	87	5	98	1	50	92
140 to 149	22	88	5	99	1	28	93
150 to 159	36	89	5	99	0	41	94
160 to 169	38	91	2	99	0	40	95
170 to 179	32	92	5	99	1	38	95
180 to 189	43	94	3	100	1	47	97
190 to 199	6	95	0	100	0	6	97
200 to 209	59	97	4	100	3	66	98
210 to 219	15	98	1	100	1	17	99
220 plus	44	100	2	100	1	47	100
Total	2,192		1,796		64	4,052	

Note: Additional data:

	Mean	Median
Number of visits in past 12 mo of patients 1st seen a year or more before	64	45
Number of visits in past 12 mo of patients 1st seen less than a year before	22	12
Number of visits in past 12 mo irrespective of when patients were 1st seen	45	25

Source: Reference 5.

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[8] L. S. Reed, E. S. Myers, and P. L. Scheidemandel: *Health Insurance and Psychiatric Care: Utilization and Cost.* American Psychiatric Association, Washington, D.C., 1972.

[13] L. S. Reed: Findings of a Survey of Selected Blue Cross and Blue Shields Plans Regarding Coverage and Utilization of Care for Mental Conditions, 1974. American Psychiatric Association. 1975 (processed), Washington, D.C.

PERCENT OF TOTAL HOSPITALIZED ENROLLEES HOSPITALIZED FOR INDICATED NUMBER OF DAYS, AND PERCENT OF TOTAL COVERED CHARGES ACCOUNTED FOR BY THOSE ENROLLEES, BY SELECTED AREAS OF RESIDENCE AND YEAR OF PAYMENT, FEDERAL EMPLOYEES BLUE CROSS AND BLUE SHIELD BASIC PLAN (HIGH OPTION), 1971–73

Area of residence and number of hospital days	Percent of total persons hospitalized			Percentage of total covered charges		
	1971	1972	1973	1971	1972	1973
District of Columbia, Maryland, and Virginia:						
30 or less	66	67	64	28	30	27
45 or less	69	78	78	41	43	42
90 or less	94	91	92	69	66	73
120 or less	97	96	97	77	78	85
Ohio:						
30 or less	66	69	64	38	39	32
45 or less	87	84	93	67	66	76
90 or less	98	100	100	92	100	100
120 or less	100	100	100	100	100	100
California:						
30 or less	68	88	70	31	27	33
45 or less	79	80	84	46	40	50
90 or less	96	91	93	83	66	72
120 or less	99	97	97	93	83	83
U.S. total:						
30 or less	80	80	80	45	46	45
45 or less	90	90	89	63	63	62
90 or less	97	97	97	84	83	84
120 or less	99	99	99	92	91	91

Source: Blue Cross/FEHB, 1974

COMPARISON OF SOME BENEFITS FOR GENERAL AND MENTAL CONDITIONS UNDER SELECTED HEALTH PLANS 1974

Company	Hospital care (days)		Outpatient physician services		Benefit is same for both types of conditions (yes or no)	
	General conditions	Mental conditions	General conditions	Mental conditions	Hospital care	Outpatient care
Alum Co. of America—steelworkers; all employees.	365–730	120	80 percent of charges over deduction $50, up to $10,000 per year.	Same	No	Yes.
Amstar Corp.—Brooklyn refinery, Longshoremen's Union (I.L.A.) Local 9.	70 plus 50 percent of cost for additional 180.	30	$7 per visit to $2,555 year; 80 percent over deduction $100 up to $10,000 per disability.	do	do	Do.
Armour & Co.—Meat Cutters Union, all prod. employees.	365	30	80 percent over deduction $300 up to $15,000 per disability.	do	Yes	Do.
California Metal Trades Association, various unions.	100	30	$6 per office visit up to 100 visits; 80 percent over deduction $50 up to $10,000 lifetime.	do	do	Do.
Campbell Soup Co.—salaried employees.	120	30	80 percent over deduction $50, no limit.	do	do	Do.
Clothing industry—men and boys clothing, clothing workers national plan.	120	30	None—except care in Union Health centers.	do	do	Do.
Continental Can Co. Inc.—Paper operations paper workers.	120	30	80 percent over dedjction $50 up to $20,000 lifetime.	do	do	Do.
FMC Corp.—American Viscose Div. textile workers (TWUA).	365	30	80 percent over dedjction of $100 of 1st $2,000; then 100 percent up to $20,000 per disability.	do	do	Do.

HOSPITAL CARE FOR MENTAL ILLNESS—COST RATES BY BENEFIT PERIOD, 1968–69

Benefit period	Cost per covered person (mental illness)	Percent of cost for all conditions	Average length of stay (mental)
Less than 30 days:			
GHI (NY) Federal, low option (10 days)	$0.34	0.8	4.3
Group Health Association Federal (10 days plus)	.65	1.2	12.5
Kaiser Hawaii (20 days)	.74	2.3	2.7
New York City Blue Cross (21 days plus 9 half days)	1.47	3.0	16.3
30 to 31 days:			
Hawaii Medical Service, Federal	.40	1.1	7.9
Tennessee Blue Cross	.89	1.6	10.5
Federal Blue Cross-Blue Shield, low option	1.11	3.5	10.7
New York (Syracuse) Blue Cross	1.60	3.8	13.4
Postmasters Benefit Plan	1.70	2.2	75.3
GHI (NY) Federal, high option	1.74	2.6	11.1
Kentucky Blue Cross	1.81	4.2	11.8
Connecticut Blue Cross	1.84	4.4	12.7
Maryland Blue Cross	1.93	3.0	14.1
Western Pennsylvania Blue Cross	1.94	2.8	10.8
Philadelphia Blue Cross	1.98	3.1	15.2
National Association of Letter Carriers	2.14	4.2	20.3
National Postal Union	2.18	3.2	15.8
St. Louis Blue Cross	3.42	6.5	14.5
45 to 50 days:			
Kaiser Oregon (45 at 80 percent) Federal	.17	.5	4.3
Washington Physicians Service (45)	.89	2.8	7.5
Kaiser Southern California (45)	1.36	3.1	15.4
Mail Handlers (45)	1.73	3.5	17.5
Rural Carriers (45)	1.93	3.7	17.9
United Federation of Postal Clerks (50 days/lifetime)	2.23	3.3	18.9
70 days and over:			
HIP Federal, low option (70)	1.22	2.5	5.8
Delaware Blue Cross (120)	1.45	3.2	23.6
Ohio (Cincinnati) Blue Cross (70 plus)	2.64	4.5	16.0
Federal Blue Cross-Blue Shield, high option (365)	3.23	5.0	16.3
HIP Federal, high option (365)	3.43	6.2	24.7
American Federation of Government Employees (200)	3.63	4.0	22.6
Virginia Blue Cross (70)	3.96	5.8	18.5
Government Employees Hospital Association ($2,000 plus 80 percent thereafter)	5.70	6.9	31.0

Note: Extracted from L. S. Reed, E. S. Myers, and P. L. Scheidemandel: "Health Insurance and Psychiatric Care, Utilization and Cost "American Psychiatric Association, Washington, D.C., 1972. Not to be quoted without permission.

COST OF PHYSICIANS' SERVICES FOR MENTAL ILLNESS UNDER PRIVATE HEALTH INSURANCE, 1968–69

Plan	Cost per covered person	Percent of cost of physicians' service for all illness	Benefits for mental illness
National Postal Union	$0.27	1.8	80 percent of 1st 10 visits, then 50 percent to 400.[1]
Group Health Association, transit workers	.56		$15 per visit to 16 visits per year (excluding long-term).
Postmasters Benefit Plan	.66	2.3	50 percent, $100 deductible.[1]
Hawaii Medical Service, Federal	.69	1.0	$300 per year 1st visit deductible.[1]
Washington Physicians Service, Federal	.71		75 percent to 20 visits per year.[1]
Mail Handlers	.79	9.4	75 percent to $300 per year; 20 visits per year.[1]
Rural Carriers	.92	6.8	80 percent to $1,500 per year, $50 deductible.[1]
Group Health Association, Federal	1.02		$15 per visit to 16 visits per year (excluding long-term).
United Federation of Postal Clerks	1.12	5.6	50 visits per lifetime at $25 (or 50 days per hospital).
National Association of Letter Carriers	1.32	9.3	80 percent to $400, then 50 percent to $3,000.[1]
Group Health Insurance, Federal low option.	1.37	3.5	$300 per year adults, $500 per year for children.
Michigan Blue Cross/Blue Shield	1.43		1st 5 visits in full, coinsurance to $400.
Kaiser Oregon, Federal	1.43	3.5	80 percent to $400.
Group Health Association, General Enrollees	1.48		$15 per visit to 16 visits per year (excluding long-term).
Group Health Insurance, Federal, high option.	1.66	3.5	$300 per year for adults, $500 per year for children.
St. Louis Labor Health Institute	1.69	8.0	Unlimited.
Maryland Blue Cross/Blue Shield	1.94		1st 5 visits in full, coinsurance to $400.
Government Employees Hospital Association.	2.32	9.2	30 visits per year.[1]
American Federation of Government Employees.	2.40	7.2	50 percent to 50 visits per year, $50 deductible.[1]

[1] Includes physicians' service in and out of hospital.

Source: Extracted from L. S. Reed, E. S. Myers, and P. L. Scheidemandel: "Health Insurance and Psychiatric Care: Utilization and Cost." American Psychiatric Association, Washington, D.C., 1972. Not to be quoted without permission.

Mr. Rostenkowski. Thank you, Dr. Johnson.

Mr. Chase?

STATEMENT OF IRVING H. CHASE

Mr. Chase. Thank you, Mr. Chairman.

I am Irving Chase of Lincoln, Mass., and I am a layman. In fact, I am a businessman, president of a company in Cambridge, Mass. I come today as a representative of the National Association for Mental Health, which is the national citizens' body in the mental health field.

We have as our basic membership in the National Association for Mental Health concerned laymen all over the country. We number approximately 1 million. We have associations in most of the States and it was my honor last week, Mr. Chairman, to address your Illinois association in Chicago.

I will not read our formal testimony. If it please the chairman, I would submit it for the record and request it be made a part of the record.

Mr. Rostenkowski. It will be inserted in its entirety.

Mr. Chase. Our message is a simple one consisting of four points.

The first one is that there is ample evidence that mental health is insurable at a reasonable and acceptable cost, and ought to be a part of any national health insurance program.

Our second point is that the need of care of the mentally ill are sufficiently different that the coverage provisions for mental illness should be different from the coverage provisions for physical illness.

The third point relates to the second point and that is that mental health coverage, mental health needs, differ from physical health needs in that there needs to be greater coverage in our opinion for outpatient care for the mentally ill than is true for the physically ill.

Likewise, we do not wish to be in the mental health field a captive of the historic patterns of health insurance which have emphasized inpatient hospital care and which have historically provided very little coverage for outpatient care.

We think the emphasis should be the other way around in mental health and we urge that there be distinct discrete packages of care in mental illness with emphasis on outpatient and partial hospitalization so as to minimize utilization of inpatient care and to concentrate it on those comparatively small numbers of people who need that kind of care.

Our fourth point is that national health insurance should be used as a mechanism to change the mental health delivery system to increase its capacity so that it can meet the needs of the many mentally ill people in our society who are not being cared for.

There are, as has been said this morning, a large number of people who are receiving care, mentally ill people receiving care, but there are a larger number who are not receiving care in this country. It is our estimation that the current delivery system is insufficient to meet that need and that it is, therefore, important that we continue the great movement which has begun in 1963 to complete a network of community mental health centers in this country so that there will be capacity.

We believe that this capacity can reside in the community mental health center system. We believe, further, that the organized setting provides some inherent advantages to care which may not always be found elsewhere.

There is a multi-disciplinary team at work and this has some advantages in utilization of scarce manpower and in utilization of all of the available manpower in the field of mental health. The psychiatrists, social workers, nurses, paraprofessionals and the community workers are terribly important in some settings.

It likewise offers the advantage of a choice of treatment modalities, broader than is generally available in other settings. It, therefore, offers the greater chance that a treatment modality will be designed to care for that patient and is tailored to meet that patient. It also offers greater opportunities for accountability as to effectiveness and costs. For this reason we believe that national health insurance should provide differential, preferential coverage for care in these organized settings.

It is those four concepts which are the basis of our formal testimony. Our testimony then proceeds to examine in detail the five principal national insurance proposals which have been proposed in the House of Representatives, comparing them on each of these categories and comparing them also on our views for coverage of psychotherapeutic drugs as well.

That will complete my statement, Mr. Chairman. I am available, as you have requested, for discussion later.

[The prepared statement follows:]

Statement of the National Association for Mental Health, Inc., Submitted by Irving H. Chase, Chairman, National Health Insurance Panel, Public Affairs Committee

I. INFORMATION ON IRVING H. CHASE AND THE NATIONAL ASSOCIATION FOR MENTAL HEALTH, INC.

Mr. Chairman and Members of the Committee: My name is Irving H. Chase. I reside in Lincoln, Massachusetts, and I am President of Henry Thayer Company of Cambridge, Massachusetts, engaged in the business of food processing and packaging.

I submit this statement in behalf of The National Association for Mental Health, Inc. I am a Past President of this Association and am currently Chairman of the National Health Insurance Panel of its Public Affairs Committee.

I have been an active citizen volunteer in the field of mental health since 1958, when I became President of the Mental Health Association of Central Middlesex, Massachusetts. Since then I have served as a director and then President of the Massachusetts Association for Mental Health, from 1967–1970. I have also served as a member, representing citizen-laymen concerns and interests, on the following bodies:

The President's Task Force on the Mentally Handicapped;
The National Advisory Mental Health Council; and
The Advisory Committee to the Governor of the Commonwealth of Massachusetts on Comprehensive Health Planning, of which I am currently Chairman.

The National Association for Mental Health, Inc. is the national citizens' voluntary organization working toward the improved care and treatment of the mentally ill; for improved methods and services in research, prevention, detection, diagnosis and treatment of mental illness; and for the promotion of mental health. The Association is, therefore, eager to insure adequate mental health coverage under a National Health Insurance Program.

II. MENTAL HEALTH COVERAGE UNDER NATIONAL HEALTH INSURANCE

A. Mental health is insurable

The publication *Health Insurance and Psychiatric Care: Utilization and Cost*[1] gives convincing evidence that over-utilization of out-of-hospital psychiatric services under private insurance plans has not occurred. In an analysis of 15 plans which included generous coverage for mental health care, it was found that the lowest annual utilization was 6.1 persons per thousand and the highest annual utilization was 21.9 persons per thousand covered. An analysis of the number of visits to psychiatrists as a percentage of visits to all physicians reported the lowest ratio of 1.1% and the highest of 4.4%. The same publication also gave information regarding the cost of mental illness benefits as compared to the costs of benefits for all illnesses under 11 major private health insurance plans. A low of 1% and a high of only 6.4% of total benefits were paid for mental health care. Even more striking are the data relating to the annual cost of all mental illness benefits per person covered. The lowest amount was $1.09 and the highest $7.32, *annually.* This cost is clearly a very modest one, particularly in view of the fact that coverage included both inpatient and outpatient care.

Further evidence of the reasonable cost of insuring mental illness is provided in a 1974 report by the National Institutes of Mental Health.[2] Current data collected from the Federal Employees Health Benefits Blue Cross/Blue Shield plan indicates that even in an insurance plan with unlimited coverage, mental health benefits "have plateaued at 7.3% of all costs incurred in the plan. CHAMPUS and Community Mental Health Centers data support the case that the issue is no longer a danger of rapidly escalating costs unique to the delivery of mental health services . . ."[3]

In addition, there is some indication that where mental health services are provided, utilization of other health services declines. A study of the Group Health Association, Inc., of Washington, D.C.[4] demonstrated that after psychiatric referral, there was a significant reduction in the utilization of physicians' services, laboratory and x-ray procedures by the patient group studied. The reduction in overall utilization was approximately 30%. A similar reduction in utilization of non-psychiatric medical care after proper psychiatric referral was made was reported in a study by the Kaiser Foundation Health Plan.[5]

These studies suggest not only that the provision of mental health services reduces the amount of non-psychiatric medical care but, even more important, that it results in provision of care which is more appropriate to the illnesses of the patients.

The above reports indicate that mental illness is insurable at a reasonable cost. So it is clear that there should be inclusion of mental health coverage in any program of National Health Insurance.

B. Recommended benefit package—An emphasis on outpatient care

The National Association for Mental Health, Inc. has developed a plan for mental health coverage in National Health Insurance. A copy of this document is appended to this statement.

In summary, this plan recommends that National Health Insurance, in covering the cost of mental health care, stimulate the development of an integrated system of mental health services according to the following principles:

1. Coverage for mental health care should not be tied to that for physical health care as the treatment and settings for care are often different
2. National Health Insurance should be structured to encourage the utilization of outpatient, ambulatory services, which are less expensive and often more effective in treating mental disorders
3. National Health Insurance should stimulate the growth and development of comprehensive Community Mental Health Centers—multidisciplinary mental health service settings emphasizing outpatient care.

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[1] L. S. Reed, E. S. Meyers, and P. L. Scheidemandel: *Health Insurance and Psychiatric Care: Utilization and Cost.* American Psychiatric Association, Washington, D.C. 1972.

[2] *Insurance for Mental Health: Trends in the Delivery and Financing of Mental Illness Services in the United States:* Report of the Work Group on Health Insurance. National Institute of Mental Health, November 1974.

[3] Ibid, p. 4.

[4] I. Goldberg, G. Krantz, B. Locke: "Effect of a Short-Term Outpatient Psychiatric Therapy Benefit on the Utilization of Medical Services in a Prepaid Group Practice Medical Program", *Medical Care,* volume 8 :5, September-October, 1970.

[5] N. Cummings, W. Follette: "Psychiatric Services and Medical Utilization", *Medical Care,* volume 5 :1, January-February, 1967.

The specific mental health benefit package advocated by the National Association for Mental Health calls for unlimited coverage of outpatient and partial hospitalization services in Community Mental Health Centers and limited coverage of outpatient services in other settings. Inpatient services are limited except for children. Coverage of psychotherapeutic medications, prescribed by a physician, is advocated for both outpatient and inpatient care settings. Use of all of the above services is subject to strict utilization review.

C. Community mental health centers and their effect

The Community Mental Health Center is a multi-disciplinary, organized setting in the community, offering a team diagnostic approach and a variety of treatment modalities. Services of the centers stress prevention, early detection, treatment and follow-up care.

The Community Mental Health Centers Act of 1963 and Amendments of 1975 (Title III, P.L. 94–63) legislate federal matching funds for the development of mental health centers which are mandated to provide numerous basic services—acute inpatient, outpatient, partial hospitalization, consultation and education, emergency services, services for children and the elderly, screening of candidates for admission to state hospitals, aftercare services and alcohol and drug abuse services (if not otherwise available) to specific geographic populations of not less than 75,000 nor more than 200,000.

There are currently 591 funded centers serving approximately 41% of the U.S. population. The development of Community Mental Health Centers reflects the dramatic shift in the locus of mental health care since 1955—from inpatient care in mental hospitals to community-based treatment. "In 1955, 48.9% of all care episodes were in state and county mental hospitals; by 1971, care in these institutions represented only 18% of the total. Over the same period . . . the proportion of care episodes in outpatient services increased from 22.6% to 45.5% . . . in 1969 federally funded Community Mental Health Centers were the setting for 10.17% of the total number of patient care episodes"[6] and as of June, 1971, this figure had reached 20%. In 1974, more than 1.7 million people are estimated to have been treated in Community Hental Health Centers, up from 1.3 million in 1973. In the absence of Community Mental Health Centers, many low income individuals could not have received mental health services. In 1973, 52% of the people seen in Community Mental Health Centers had incomes below $5,000.

Although many factors influence change in the utilization of mental health services, the introduction of Community Mental Health Centers has been a significant factor in the market decrease in the resident population of state mental hospitals. The average patient residence in state hospitals during the period 1970–74 dropped from 347,768 to 219,102 or nearly 40%. This reduction in census has important financial implications, as the average daily cost per patient between 1970–74 rose from $14.89 to $30.86.

Community Mental Health Centers are providing a viable alternative to siolated, custodial care for the mentally ill. They have the responsibility and, if properly financed, the capability of providing quality care to all Americans. The National Association for Mental Health therefore advocates that any program of National Health Insurance provide for further growth of Community Mental Health Centers.

III. MENTAL HEALTH COVERAGE IN H.R. 21 (CORMAN), H.R. 1 (ULLMAN), H.R. 5990 (BURLESON), H.R. 6222 (FULTON), AND H.R. 10028 (WAGGONNER)

A. Outpatient services

H.R. 21 (Corman) provides unlimited coverage provided in an organized setting (defined as group practice organization, hospital, Community Mental Health Center, mental health clinic) and 20 visits per benefit period otherwise.

H.R. 1 (Ullman) requires co-insurance and provides for outpatient services (including partial hospitalization) up to 270 days per benefit period (on the basis of exchange of outpatient days for inpatient days on a 3 for 1 basis).

H.R. 5990 (Burleson) provides for unlimited coverage for hospital-based outpatient psychiatric care (maximum 20% coinsurance) and 20 outpatient mental health visits per year in a Community Mental Health Center or with a private physician (maximum 50% coinsurance).

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[6] *Financing Mental Health Care in the United States: A Study and Assessment of Issues and Arrangements.* National Institute of Mental Health, 1973.

H.R. 6222 (Fulton) includes unlimited emergency and outpatient hospital services for psychiatric care (with 20% coinsurance).

H.R. 10028 (Waggonner) *title I* includes unlimited outpatient coverage for care in a qualified community mental health center and five visits per year to a private psychiatrist after a $2,000 medical deductible has been met; *title II* includes the same coverage as title I without the deductible for low-income individuals and their families; *title III* requires $400 minimum of outpatient mental health coverage be provided to certify a private basic health insurance policy.

NAMH recommendations for outpatient services include unlimited coverage for services when provided in a Community Mental Health Center and otherwise limited to 20 visits per one-year benefit period, as suggested in H.R. 21, and as provided with some variation in H.R. 10028. We recommend that co-insurance requirements under H.R. 1, H.R. 5990, and H.R. 6222 be dropped, as co-insurance often serves as a barrier to early treatment. The importance of early outpatient treatment of mental illness, which often heads off more costly inpatient care, cannot be overemphasized. Title III of H.R. 10028 should include unlimited coverage for outpatient care in a Community Mental Health Center and limited coverage for care with a private psychiatrist (as do titles I and II).

B. Partial hospitalization services

H.R. 21 (Corman) provides unlimited coverage if furnished by a group practice organization, Community Mental Health Center or other mental health center furnishing comprehensive mental health services, and 60 days per benefit period if furnished by a hospital.

H.R. 1 (Ullman) considers partial hospitalization as a form of outpatient care and thus the prescription for outpatient coverage applies here—up to 270 days per benefit period (on the basis of exchange of partial hospitalization days on a 3 for 1 basis).

H.R. 5990 (Burleson) and H.R. 6222 (Fulton) have no provision for partial hospitalization services.

H.R. 10028 (Waggonner) *title I* includes unlimited coverage for partial hospitalization services in a qualified community mental health center or an accredited medical institution; *title II* includes coverage for partial hospitalization services in the same settings as title I but the length of coverage is not clear; *title III* has no provision for partial hospitalization coverage.

NAMH recommendations for partial hospitalization services suggest that this form of outpatient intensive care should be covered on an unlimited basis in a Community Mental Health Center.

C. Inpatient services

H.R. 21 (Corman) provides 45 days inpatient care per benefit period in either a psychiatric or other hospital.

H.R. 1 (Ullman) requires co-insurance and provides 90 days inpatient care per benefit period in a hospital.

H.R. 5990 (Burleson) includes unlimited coverage for hospital inpatient care in a general or psychiatric hospital.

H.R. 6222 (Fulton) provides for unlimited inpatient psychiatric care.

H.R. 10028 (Waggonner) *title I* includes coverage for unlimited inpatient care in an accredited medical institution after a 60 day hospital deductible is met; *title II* includes coverage for 60 days/benefit period of inpatient care in an accredited medical institution for low-income individuals and their families; *title III* requires a minimum of 60 days/year of inpatient care be provided to certify a private basic health insurance policy.

NAMH recommendations for inpatient services include limiting inpatient coverage, except for children, to 45 days per one-year benefit period in a psychiatric or other hospital. These limits should be imposed in H.R. 1, H.R. 5990, H.R. 6222, and H.R. 10028 except for children 18 years and younger, for whom inpatient services should be unlimited. In addition, H.R. 1 and H.R. 10028 (title III) should be amended to include inpatient coverage in a psychiatric hospital if that is not implicitly covered now in the term "hospital".

D. Medications

H.R. 21 (Corman) prescribes a formulary of drugs (to be established) be covered if prescribed by a physician to persons enrolled in participating group practice organizations, individual practice associations, hospitals (inpatient or outpatient) or as inpatients in a skilled nursing home.

H.R. 1 (Ullman) requires co-insurance per prescription and covers medications in a formulary (to be established) if prescribed by a physician for inpatient or outpatient care.

H.R. 5990 (Burleson) provides unlimited coverage for prescription medications on an outpatient or inpatient basis (with coinsurance).

H.R. 6222 requires co-insurance and covers inpatient medications only.

H.R. 10028 (Waggonner) *title I* provides no coverage for drugs; *title II* provides coverage for psychotherapeutic drugs on an outpatient basis to avoid hospitalization; *title III* provides no guidelines recommending coverage of drugs in basic health insurance policies.

NAMH recommendations for medications include coverage for inpatient and outpatient drugs when such medications are prescribed by a physician. H.R. 21 and H.R. 6222 should be amended to include coverage for psychotherapeutic medications for outpatient care. H.R. 10028 should include coverage for psychotherapeutic drugs in titles I and III.

V. SUMMARY

Reputable data confirm that mental illness is insurable at a reasonable cost and adequate coverage for mental illness, which strikes one in ten, should be included in any program of National Health Insurance.

The national Association for Mental Health, Inc. recommends that such coverage emphasize ambulatory, outpatient services and stimulate the growth and development of Community Mental Health Centers which can provide appropriate care for the first time to the thousands of mentally ill persons whose major resource heretofore has been long-term care in public mental hospitals.

H.R. 10028 (Waggonner), H.R. 21 (Corman) and H.R. 1 (Ullman) have made a good effort in this direction. We have suggested ways in which these and other proposals could be amended to stimulate rapid and constructive changes in the mental health care delivery system of this country.

A Plan of Coverage for the Mentally Ill in National Health Insurance

The National Association for Mental Health, after a year of concentrated study by the Association's Task Force on National Health Insurance, has reached several major conclusions regarding the inclusion of mental illness in National Health Insurance:

(1) Mental illness is insurable at a reasonable cost;

(2) Any system of National Health Insurance should stimulate the growth and development of community mental health centers; and

(3) National Health Insurance should promote an integrated and coordinated system of mental health service delivery.

In response to requests by the citizens in our Association and members of Congress, we have developed a proposal that outlines our recommendations regarding specific coverage for mental illness in National Health Insurance. On page 2 is a brief explanation of the information on which we based our conclusions. Our recommendations regarding mental health services to be included in any plan for National Health Insurance follow on page 3.

We are committed to supporting National Health Insurance legislation to the extent that it incorporates our recommendations for services.

MENTAL ILLNESS IS INSURABLE AT A REASONABLE COST

Many reasons are given for excluding mentally ill persons from insurance plans, but the most damaging reason is based on the myth that including mental illness causes rates to soar. This myth has clearly been refuted by a number of studies. For example, the Health Insurance Plan of Greater New York found that it could provide mental illness coverage to a family of three or more for $2.70 a month, which included outpatient and inpatient psychiatric treatment with no upper limit on the number of services and with no cost to the patient.

Mental health care is not only possible at a reasonable cost; such coverage may also reduce inappropriate utilization of other health services. In a study[1] of the Group Health Association in Washington, D.C., it was demonstrated that the provision of mental health services reduced substantially the amount of non-psychiatric medical care provided to a given population.

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[1] Goldberg, L., Krantz, G., Locke, B.: "Effect of a Short-Term Outpatient Psychiatric Therapy Benefit on the Utilization of Medical Services in a Prepaid Group Practice Medical Program," *Medical Care,* Sept.-Oct. 1970, vol. 8, No. 5.

The myth is just that. There is no sound evidence for excluding mental illness from National Health Insurance because of cost. Our organization is pledged to bring this fact before the public and our elected officials so they may judge the cost issue on its merits.

ANY SYSTEM OF NATIONAL HEALTH INSURANCE SHOULD STIMULATE THE GROWTH AND DEVELOPMENT OF COMMUNITY MENTAL HEALTH CENTERS

There are a number of reasons why we support the concept of National Health Insurance promoting the development of community mental health centers. It is a fact that the community mental health centers are playing an important role in decreasing the utilization of state mental hospitals. A 1970 survey of 92 community mental health centers indicates that state mental hospitals which are served by well-established (in operation three years or longer) community mental health centers have less than half the admission rate of the national average.

There are additional reasons why we support centers. Centers provide a wide range of treatment alternatives—which are suited to the needs of the patient. They provide service close to home. They are accessible to citizen "watchdog" activities. They hold the major hope for completely reversing the practice of "warehousing" the mentally ill in massive, distant, custodial institutions. Most important, the center, through consultation and education, and through its outreach to the community can help to prevent the onset of mental illness and thereby reduce the number of persons who might otherwise require treatment.

Centers have demonstrated their ability to provide an effective alternative to long-term custodial care and have earned the right to be included in any system of National Health Insurance.

NATIONAL HEALTH INSURANCE SHOULD PROMOTE AN INTEGRATED AND COORDINATED SYSTEM OF MENTAL HEALTH SERVICE DELIVERY

National Health Insurance not only provides an opportunity for delivering more mental health services to people; it can and should influence the delivery system.

Many community mental health centers have already demonstrated that they can provide an integrated coordinated system of mental health service delivery. We think it makes good sense to extend this system by mandating affiliation between centers and state mental hospitals as well as other organized deliverers of mental health care. Therefore, we are requiring, in the following outline of services, that all facilities providing services shall be affiliated with community mental health centers in their geographical area.

RECOMMENDATIONS OF THE NATIONAL ASSOCIATION FOR MENTAL HEALTH FOR CATEGORIES OF SERVICE FOR MENTAL HEALTH COVERAGE UNDER NATIONAL HEALTH INSURANCE

Concept

Comprehensive coverage.—The National Association for Mental Health supports comprehensive coverage of mental and emotional disorders under National Health Insurance. Such coverage must provide compensation for active care, including preventive, diagnostic, therapeutic, supportive, or rehabilitative services in all categories of service delivery. There should be no limitations of coverage and no discrimination by providers based upon age, sex, race, creed or economic circumstance. Persons in preventive custody, correctional institutions, juvenile detention centers, and court designated treatment facilities shall not be excluded from the provisions of NHI. Such coverage under NHI should be guaranteed as a matter of right to health.

Encouraging development of community mental health centers.—The National Association for Mental Health is committed to securing mental health coverage under NHI which encourages and facilitates the continued development and use of community mental health centers (CMHCs). All facilities providing services shall be affiliated with any CMHCs in their geographical area. All treatment facilities must be approved by a state recognized health planning and accrediting board. These facilities may include, but not be limited to, CMHCs, state mental hospitals, private mental hospitals, general hospitals, mental health clinics, comprehensive health service organizations, health maintenance organizations, drug and alcohol treatment centers, and schools and other treatment facilities providing special services to emotionally disturbed children and youth.

SPECIFIC MENTAL HEALTH COVERAGE UNDER NATIONAL HEALTH INSURANCE

I. Services provided on an unlimited basis

A. Outpatient services (Excluding professional services by private practitioners).—1. There shall be no limit placed on mental health outpatient services. Each client case which has continued for 90 calendar days shall be reviewed by an independent utilization review board. Subsequent reviews shall be made every 90 calendar days.

B. Partial hospitalization services.—1. There shall be no limit placed on partial hospitalization services. Each client case which has continued for 60 calendar days shall be reviewed by an independent utilization review board. Subsequent reviews shall be made every 60 calendar days.

II. Services provided on a limited basis

A. Professional services by private practitioners.—1. Consultation by private practitioners shall be limited to twenty (20) consultations per each one-year benefit period. The first seven consultations, per each one-year benefit period, shall be covered in full. Private professional consultations may be provided by private practitioners in categories designated by the Secretary and who hold a valid license or certificate issued by an appropriate governmental agency to provide diagnostic or therapeutic services.

2. Private professional services shall be subject to a periodic review by an independent utilization review board. The review shall be based upon a random sample.

B. Inpatient services.—1. Inpatient services for adults shall be limited to 45 days of active treatment per each one-year benefit period. No continuous stay of more than 20 days shall be permitted without approval by an independent utilization review board. Coverage of inpatient services shall not be continued after the third day following delivery of notice that continued inpatient services are not therapeutically necessary. Those client cases found by the utilization review board to need treatment for more than 45 days shall be eligible for NHI inpatient coverage under provisions for chronic long-term care.

2. Inpatient services for children 18 years and younger shall be unlimited. Each client case shall be reviewed monthly by an Independent Utilization Review Board.

III. Services provided on the same basis as chronic medical conditions

A. Chronic long-term care.—1. Coverage under NHI for mental health care in an extended care or intermediate care facility, foster home, or small group home, which has primarily long-term treatment and maintenance objectives should not be less than the most favorable coverage available for long-term treatment and maintenance provided for any other chronic medical condition.

2. Interviews with clients and review of case records should be conducted at least twice annually by an independent utilization review board to determine the nature and necessity for continued treatment and maintenance.

IV. Corollary considerations and definitions

A. Other services.—1. The cost of covered mental health services shall be reimbursable even though care is provided in non-health care facilities (e.g. schools, day care centers, correctional institutions, etc.)

B. Active treatment.—Active, preventive, diagnostic, therapeutic, supportive, or rehabilitive services shall mean that all treatment modalities consist of a planned and written program of daily activities or services based upon diagnosis and designed to prevent regression, improve adaptive capability, or maximize ability to live independently. Such services may include, but are not limited to: drugs, testing, nursing, psychotherapy, home visits, counseling, group therapy, casework, and other professional and paraprofessional services, which are a part of active care.

C. Affiliation.—Affiliation shall mean that those facilities delivering service shall be required to have a written contractual agreement binding on both parties and providing for the following:

1. Cross-consultation and exchange of staff resources;

2. Free accessibility of all case and medical information ; and

3. Planned and coordinated referral and transfer of clients from one service program to another.

D. Independent utilization review board (IURB).—This Board shall be comprised of mental health professionals and paraprofessionals and informed laypersons. In no instance should members of the IURB be employees or Board members of the organization being reviewed. Access to information upon which judgment can be made and authority to enforce this judgment should be provided by NHI administrative regulations. Such regulations should protect the confidentially of individual patients' records. The purpose of the utilization review process shall be as follows :

1. To determine the nature and necessity of continued treatment :

2. To safeguard the rights of clients receiving treatment, including the rights of confidentiality ; and

3. To assure quality care of an active nature.

E. Citizen boards.—Citizen Boards should be created at the various levels of administration to set standards and evaluate all providers. They shall have ultimate responsibility for governing the program and for assuring an integrated and coordinated system of mental health service delivery, specific to the needs of the geographic area. There should be substantial representation on all Citizen Boards from consumers, minority groups, the poor, and from professionals and laypersons with knowledge of mental health and mental illness. Laypersons not engaged in providing services to the mentally ill should constitute a majority of every Board.

F. Other critical mental health services.—Education-consultation, manpower training and development, research and evaluation, currently provided for by the Community Mental Health Centers Act of 1963, should be continued and funded separately from NHI through categorical funds or project grants.

Approved by the NAMH Board of Directors, February 1, 1974.

PUBLIC AFFAIRS COMMITTEE TASK FORCE ON NATIONAL HEALTH INSURANCE

Hilda H. Robbins, Chairperson, Past-President, Pennsylvania Mental Health, Vice Chairman NAMH Public Affairs Committee.

Jerry Cole, Insurance Consultant, Past-President, Kansas Association for Mental Health.

Kenneth Graver, M.D., Director, Ohio Department of Mental Health and Mental Retardation.

Dorothy Knox, M.S.W., Chairperson, Intervention Concentration, School of Social Welfare, State University of New York at Stony Brook, Member NAMH Executive Committee.

Mr. Rostenkowski. Thank you, Mr. Chase.

Mr. Clotworthy?

STATEMENT OF WILLIAM B. CLOTWORTHY, M.D.

Dr. Clotworthy. Thank you, Mr. Chairman.

I am William Clotworthy, I am the clinical director of the Christ Child Institute and am in private practice in nearby Maryland.

NATIONAL HEALTH INSURANCE BENEFITS FOR THE MENTALLY ILL CHILD

Any meaningful plan for national health insurance must encompass the significant health needs of the insured population. A common and, all too often, disabling form of human disorder is mental illness. Hence a basic requirement for any such insurance plan is coverage for mental disorders; in fact, equal coverage for mental illness. By equal coverage we mean that there should be no more limitations on mental health services than there are on services for physical diseases.

The term "mental illness" has different meanings at different times of life. The psychiatric needs of children differ from those of adults, so that in meeting these needs the diagnostic methods, the training of clinicians, the treatment techniques, the nature of institutional arrangements, and the degree and the quality of family involvement necessary all vary in considerable degree from the treatments that are appropriate for adults. The following is an explanation of these differences:

1. The immaturity of children makes them more vulnerable to stress and far more susceptible to emotional injury than is true for adults.

2. The dependency of children makes the environmental factors that surround them far more critical in planning service delivery. Thus, work with day care settings, with schools, and with families are necessary factors all through childhood.

3. The disturbed child who goes untreated often faces a far longer period of more profound disability than is true of emotional disorders later in life.

4. A peculiar demand that is made on treatment methods for children is that childhood disorders tend to arrest the unfolding of personality in important ways. The sick child not only experiences pain and disability, but he or she undergoes personality arrest. The child fails to grow in full and mature ways. The need to relieve pain and restore function is part of all treatment; the clinician who deals with child mental illness must, in addition, work to free up the child's development so that emotional and/or intellectual stunting will not persist.

The implication of these considerations is that all planning and funding for children's programs must be designed to be appropriate for the developmental stages through which children pass. There are quite different patterns that are apropriate for infants, for toddlers, for preschoolers, for grade school children, for youngsters at the preteen level, for adolescents and for young adults. Indeed, it makes no sense merely to plan for "children" unless one embraces the full variety and the unfolding needs of each developmental level.

In planning mental health services for children it is important to consider also the degree of severity of the problem and/or the complexity of the intervention necessary. Some types of intervention clearly must be covered by national health insurance, while others might or might not. I wish to make this distinction. Preventive programs and services for mild disorders might not necessarily be covered.

In spite of the tremendous potential for benefits to our children, programs for prevention of psychiatric disabilities are not well developed at the present time. Pioneer efforts can be found in programs like Headstart, Healthstart, high-quality well-baby clinics, et cetera where there are psychiatric or psychological consultations. Such programs need funding under some mechanism.

There are other existing programs for vulnerable children or children "at risk" who do not have obvious psychological dysfunction. They have other disabilities often of a chronic nature, or they are in family or social settings that require intervention to prevent the development of psychiatric disorder. These children comprise a very large population group and often require intensive and ongoing social interventions to preserve healthy growth and development and to diminish the need for direct psychiatric services later.

Such social services would normally be provided through mechanisms other than national health insurance. Some examples of such "at risk" children are the many youngsters with chronic physical disabilities. Such as blindness, deafness, congenital abnormalities, and the like. Other examples are children reared in conditions of severe deprivation; children caught up in major natural disasters; children involved in serious parental problems such as alcoholism or bitter custody battles, or the loss of a parent through death, desertion or chronic illness, and so forth. I am still talking about those kinds of children with problems who might not be covered with national health insurance.

Other examples then are the children with minor and transient difficulties involving social and emotional elements. These youngsters can usually be managed without psychiatric diagnosis or treatment. They require help from agencies or other social institutions such as schools, counselors, ministers, Big Brothers, visiting nurses, and the like. Psychiatric consultation to these agencies and institutions is a valuable source of mental health expertise and should be seriously considered in weighing fundable health compensation. This might or might not be covered under national health insurance.

The following five categories of children with mental illness or disabilities ranging from mild to the most severe should definitely be covered by national health insurance:

1. Children with even mild degrees of retardation pose a special problem. These youngsters are already at risk, and even minor degrees of emotional difficulty will pose a severe threat to functioning and development. Therefore, early use of psychiatric services is required by this group.

2. Children with evident symptoms of mental or emotional disorder require psychiatric diagnosis and treatment. Such diagnostic studies include psychiatric interview, psychological testing and family interviews by psychiatrist or social workers. Special educational study and neurological examination and the like may also be necessary.

The large majority of such children will be adequately served by outpatient treatment. Some will need only diagnostic study and evaluation and followup interviews. Some may require further regular treatment for 3 to 6 months. Others may require intensive outpatient treatment up to three to four times a week for a period of several years. The techniques of the required outpatient treatment will vary depending on the individual patient. They may include group, individual and/or family psychotherapy, drug treatment, therapeutic schooling, and others.

3. A smaller group of children with established psychiatric diagnoses of mental or emotional disorder will require additional psychiatric intervention in the form of day hospitalization or day treatment, or therapeutic group homes.

4. A small number of adolescent patients may require brief hospitalization, or residential treatment to deal with an episode of transient severe mental difficulty. Following discharge, a further period of outpatient treatment will be required.

5. The most disturbed group of children with obvious severe psychiatric disorders of long-standing duration will require highly structured, long-term intensive treatment environments. Depending on the

individual patient, either a hospital or residential treatment setting will be necessary for adequate care and treatment. It is important to emphasize here that duration of inpatient treatment for children is of a different magnitude from inpatient treatment of adults. Instead of a few days to a few months, it is apt to be 1 to 3 years.

Children in need of this last resort type of treatment need to be removed from home to live in a specially devised environment which provides therapeutic interaction through all the waking hours. They must live in this environment long enough that they can catch up in their lagging development so that they can be returned home.

The duration of inpatient treatment for adolescents as opposed to younger children is apt to be more like the length for that of adults.

Adequate psychiatric treatment for children must include two other features which differ from adults. To better understand and help the child, the psychiatrist and parents must work together. It is essential for the parents to understand their contribution to the child's problems, so they can correct these deficiencies and, in addition, the parents must learn the art of managing the child at home. Coverage for therapeutic interviews and for counseling with members of the family household, particularly parents or parent surrogates, should be provided.

In treatment of a mentally ill child direct psychiatric interviews and consultation by the child psychiatrist with teachers, juvenile court personnel, and other social agencies are often essential. The psychiatrist, for example, needs to know about the child's behavior in school and he or she may wish to make recommendations for the handling of the child by the teachers. Reasonable coverage for this time-consuming consultative services should be included in national health insurance.

Finally, I wish to conclude with the American Academy of Child Psychiatry's position on mental health coverage in general for children and adults.

Coverage of all varieties of accepted existing mental health services are necessary. A mode of treatment appropriate for one emotionally disturbed person may not be helpful to another. A pluralistic mental health service system is necessary to meet individual needs for care which would allow for the most appropriate and efficient treatment for the patient and prevent stagnation and rigidity in the development of mental health care.

Freedom to choose the practitioner and type of mental health treatment is a fundamental principle in the health field. The patient and his family must have the right to choose treatment by the qualified mental health professional of their choice. The patient and his family must also have the right to choose treatment in any of the various service delivery systems; for example, private practice, community mental health centers, health maintenance organizations, et cetera. Freedom of choice prevents the entrenchment of a single form of service delivery and encourages innovative patterns of care.

In any third-party payment system coinsurance and deductibles should not interfere with the provision of basic benefits and should be related to the patient's capacity to pay.

The patient must feel comfortable about seeking help for mental illness. It is essential for his own protection that all information about the patient's emotional health be kept confidential. People will not seek mental health assistance if they are fearful of the violation of their privacy.

Finally, the American Academy of Child Psychiatry strongly supports the concept of utilization and peer review. The legally constituted Professional Standards Review Organizations is one means of assuring proper utilization and quality of services provided. To prevent abuses of coverage such review mechanisms should be an integral part of a national health insurance program.

The American Academy appreciates the opportunity to appear before the Health Subcommittee and welcomes any questions which you may have.

Thank you, Mr. Chairman.

Mr. ROSTENKOWSKI. Thank you, Doctor.

Dr. Taylor?

STATEMENT OF ROBERT L. TAYLOR, M.D.

Dr. TAYLOR. Mr. Chairman, members of the committee, my name is Robert L. Taylor. I am a staff psychiatrist with the Community Services Division of the Texas Department of Mental Health and Mental Retardation. My testimony today, however, does not necessarily reflect the views of that department.

As legislators considering the question of mental health care under a national health insurance plan, you have the unenviable task of attempting to clarify a field of endeavor which is extremely ill defined. Mental health care cannot be viewed as simply just another form of medical care.

Many of the most devastating mental and emotional disturbances are essentially "problems in living"; that is, problems that result from unsatisfactory personal relationships, low self-esteem or recurrent ways of behaving that consistently fail to satisfy certain basic human needs. These are not readily diagnosable in a lab. They do not respond after so many tablets of medication. They are not illnesses in the traditional sense of the word.

This is not to deny that there are certain forms of severe mental disorders that are illnesses for which medical care is appropriate. It is to say, however, that such problems represent only a small fraction of this nation's serious mental health care needs. To construe all of these "problems in living" as illnesses requiring medical treatment would be, I think, an incredibly costly proposition resulting in inappropriate responses to these problems.

As one attempts to place the field of mental health care in context, I think this is an important fact to keep in mind.

Now I would like to consider some of the findings that have emerged over the past decade, which I think are significant to any discussion of mental health coverage under a national health insurance plan. Let me begin with psychiatric hospitalization.

Although this has been highlighted in a number of proposals for national health insurance, it, in fact, seems to be less effective as a means of dealing with mental health problems than are a number of less expensive alternatives.

Several studies, for example, have demonstrated the feasibility and relative greater effectiveness of partial care compared to psychiatric hospitalization. In 1970 after 16 months of operation, the psychiatric staff of a day treatment center in Bethesda, Md. reported that more than 96 percent of their patients, the majority of whom had initially been referred from other physicians expressly for hospitalization, did well with day care alone.

In a controlled study Hertz compared the efficiency of day care to hospitalization. Forty-five patients representing a wide variety of psychiatric diagnoses were randomly assigned to each treatment approach. A tabulation of days spent in treatment from beginning to discharge showed an average of 138.8 days for hospitalized patients in contrast to 48.5 days for day care.

> The results showed that on virtually every measure used to evaluate outcome there was clear evidence of the superiority of day treatment. Not only did patients return to full-time life in the community and resume their occupational roles sooner, but they were more apt to remain in the community without subsequent readmission to the hospital.

In this study the overall cost of day care was one-sixth for that of hospitalization.

Outpatient intervention also appears generally superior to phychiatric hospitalization. Langsley randomly assigned 300 patients "requiring immediate hospitalization" to a university psychiatric hospital or to outpatient family crisis therapy. At 6- and 18-month followups the outpatient group was doing as well as the hospitalized group on two measures of social adapation and were managing personal crises more effectively. In addition, the 18-month evaluation showed the hospital group subsequently spent more than twice as many additional days as psychiatric inpatients than did the outpatient group. Hospitalization as one of its undesirable side-benefits seems to lead to more hospitalization.

To summarize, there is substantial evidence to support the contention that hospitalization for a large spectrum of emotional and mental problems is less effective than a number of less expensive alternatives; and, that in many cases hospitalization actually seems to be detrimental. I think it is important to realize, however, that the use of psychiatric hospitalization has frequently resulted from an absence of more appropriate service alternatives. This has frequently resulted from the fact that coverage often does not provide for alternative services. The provision of alternative services is the key to the avoidance of inappropriate and costly psychiatric hospitalization.

Now let me briefly review psychotherapy and the mental health service provider issue.

Psychotherapy sounds like a scientific term. It is not. There are literally hundreds of differing, sometimes contradictory, approaches that fall under the rubric "psychotherapy." There exists a growing and impressive body of evidence indicating that the effectiveness of psychotherapy is dependent much more on personality variables than on type and length of training or possession of a particular degree, including a medical degree; or technique or theory.

Study after study has failed to demonstrate a significant outcome difference in psychotherapy as practiced by psychologists, social workers, psychiatrists and a whole host of nonprofessional counselors. It is in this context that you must evaluate the claim that continues to be made by the American Psychiatric Association, that optimally a physician, preferably a psychiatrist, should provide or at least supervise all psychotherapy. Maintenance of this highly questionable position, that psychotherapy necessitates the services of a physician produces a pseudo-scarcity of manpower which, in turn, inflates cost of services. If psychotherapy were freely permitted by all qualified providers, the cost would be considerably less.

Any national health insurance plan which encourages the provision of psychotherapy by physicians will actually provide further incentive for the continued misuse of American psychiatrists who, in spite of their expensive and highly technical medical training, spend approximately 40 percent of their time in the office practice of psychotherapy. Consequently, public institutions across the Nation are forced to rely on foreign medical graduates to an embarrassing degree to provide care for the most severely mentally ill persons.

Finally, I go to the class-specific nature of traditional mental health care services.

Utilization of mental health services varies directly with extent of education and level of income, a point which was noted as early as 1960 by the Joint Commission on Mental Health. This is a pervasive finding and it is not merely the result of financial inaccessibility. Insurance plans providing liberal mental health benefits experience the same class-selective utilization.

What I am saying is that lower socioeconomic groups people do not avail themselves of these services. For example, a group health insurance study project on psychiatric benefits demonstrated the following findings:

1. Families with incomes of over $10,000 used significantly more psychiatric services than those with lower incomes.
2. White collor workers used twice as much care as blue collar workers.
3. Salaried professionals received psychiatric benefits eight times more often than unskilled workers.
4. Individuals with a college degree had almost 10 times the number of office visits for psychotherapy as did those with a grade school education.

This does not mean that mental health services per se are not relevant to these people who have avoided traditional psychiatric services. In fact, the best epidemiological evidence we have suggests that this group has significantly greater numbers of problems. What it really says is that there is a need for a broader range of services and service providers, and a modification of existing approaches to mental health care, different ways of organizing and presenting these services so these people can accept them and make use of them.

Based on the points that I have made, let me briefly conclude with some general recommendations concerning mental health coverage under a national health insurance plan.

1. I think legislators faced with a demand for mental health services about which there is no professional consensus will do well to rely heavily on consumers themselves in framing mental health coverage under a national health insurance plan. Consumer input concerning the type of services needed and an ongoing consumer role in monitoring such services, I think, will provide the best guarantee of responsive mental health care.

2. Coverage incentives should be designed which encourage organized systems of mental health care such as community mental health centers. Such incentives would facilitate service continuity, which is a very important element in mental health care, and would maximize the service alternatives available to an individual.

3. If services must be restricted because of fiscal limitations—and I assume that they must—consideration should be given to establishing an annual per-capita dollar limitation within which the consumer can purchase from a wide variety of mental health services in whatever combination best addresses his particular problems.

I think it should be possible for a consumer to use his annual mental health care allocation as a capitation prepayment for membership in an organized mental health care system, much along the lines of an HMO arrangement. This would encourage cost-effective service approaches and appropriate manpower utilization in a field which because of the "vagueness" of its treatment objectives is particularly subject to excessive utilization in the interest of profit.

4. Consideration should be given to establishing a form of "institutional licensure"; that is, a mechanism for licensing organized mental health programs. These licensed programs, in turn, would assume responsibility for certifying and recertifying various service providers on the basis of competency and interpersonal skills.

5. All mental health services funded under a national health insurance plan should be subject to utilization review and peer review means for monitoring duration and quality of services.

6. Finally, some form of catastrophic coverage should be extended to persons with the demonstrated chronic mental incapacity to care for themselves. Rather than paying for extended hospitalization, however, such coverage should provide for more effective service alternatives.

Thank you.

[The prepared statement follows:]

STATEMENT OF ROBERT L. TAYLOR, M.D., STAFF PSYCHIATRIST, COMMUNITY SERVICES DIVISION OF THE TEXAS DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION [1]

Mr. Chairman and Members of the Subcommittee on Health: My name is Robert L. Taylor. I am a staff psychiatrist with the Community Services Division of the Texas Department of Mental Health and Mental Retardation. My testimony today, however, does not necessarily reflect the views of that Department.

As legislators considering the question of mental health care under a National Health Insurance Plan, you have the unenviable task of attempting to clarify a field of endeavor which is extremely ill-defined. Mental health care cannot be viewed as simply a special form of medical care. Many of the most devastating mental and emotional disturbances are essentially "problems in living"; that is, problems that result from unsatisfactory personal relationships, low self-esteem or recurrent ways of behaving that consistently fail to satisfy the most basic human needs. These problems are not diseases: they are not readily diagnosed by laboratory tests and they are not resolved by a person spending so many days in the hospital or taking prescribed medications. This is not to deny that there are certain forms of severe mental disorders that are illnesses for which medical care is appropriate. It is to say, however, that such problems represent only a small fraction of this nation's mental health care problems. To construe all of these "problems in living" as illnesses requiring medical treatment would be an incredibly costly proposition resulting in inappropriate responses to these problems.

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[1] This testimony does not necessarily represent the views of the Texas Department of Mental Health and Mental Retardation.

As one attempts to place the field of mental health care in context, it is important to highlight some of the findings that have emerged over the past decade.

Consider psychiatric hospitalization. Although this form of intervention has been highlighted in most proposals for National Health Insurance, it in fact seems to be less effective as a means of dealing with mental problems than are a number of less expensive alternatives.

ALTERNATIVES TO PSYCHIATRIC HOSPITALIZATION

Several studies, for example, have demonstrated the feasibility and relative greater effectiveness of partial care compared to psychiatric hospitalization. In 1970 after sixteen (16) months of operation, the psychiatric staff of a day treatment center in Bethesda, Maryland, reported that more than 96% of their patients, the majority of whom had initially been referred from other physicians expressly for hospitalization, did well with day care alone. In a controlled study, Hertz compared the efficiency of day care to hospitalization. Forty-five patients representing a wide variety of psychiatric diagnoses were randomly assigned to each treatment approach. A tabulation of days spent in treatment from beginning to discharge showed an average of 138.8 days for hospitalized patients in contrast to 48.5 days for day care.

"The results showed that, on virtually every measure used to evaluate outcome there was clear evidence of the superiority of day treatment. Not only did patients return to full-time life in the community and resume their occupational roles sooner, but they were more apt to remain in the community without subsequent readmission to the hospital."

On a per diem basis the cost of providing day care is approximately one-half that of 24-hour care. But in the study cited, day care patients were in treatment only one-third as long as their hospital counterparts; thus, the overall cost for their care would have been one-sixth of that for hospitalization. Outpatient intervention also appears generally superior to psychiatric hospitalization. Langsley randomly assigned three hundred (300) patients "requiring immediate hospitalization" to a university psychiatric hospital or to outpatient family crisis therapy. At six and eighteen month follow-ups the outpatient group was doing as well as the hospitalized group on two measures of social adaptation and were managing personal crises more effectively. In addition, the 18-month evaluation showed the hospital group subsequently spent more than twice as many additional days as psychiatric inpatients than did the outpatient group.

Langsley has tabulated the costs incurred from managing a broad range of mental disturbances three different ways. Cost differentials for outpatient intervention versus acute hospitalization versus extended hospitalization are impressive.

TABLE I.—*Psychiatric treatment cost*

Mode of treatment	*Cost per case*
Outpatient crisis intervention	$162.00
Acute hospitalization (average stay—8.6 days)	943.00
Extended hospitalization (average stay—58 days)	1,922.00

To summarize, there is substantial evidence to support the contention that hospitalization for a large spectrum of emotional and mental problems is less effective than a number of less expensive alternatives; and, that in many cases hospitalization actually seems to be detrimental. It is important to realize, however, that the use of psychiatric hospitalization has frequently resulted from absence of more appropriate and less expensive facilities and service approaches. The provision of alternative services is the key to the avoidance of costly psychiatric hospitalization.

PSYCHOTHERAPY AND MENTAL HEALTH SERVICE PROVIDERS

Psychotherapy sounds like a scientific term. It is not. There are literally hundreds of differing—sometimes contradictory—approaches that fall under the rubric "psychotherapy". There exists a growing and impressive body of evidence indicating that the effectiveness of psychotherapy is dependent more on personality variables than on type and length of training or possession of a particular degree, including a medical degree. Study after study has failed to demonstrate a significant outcome difference in psychotherapy as practiced by psychologists, social workers, psychiatrists and a whole host of "non-professional" counselors.

It is in this context that you should evaluate the claim that continues to be made by the American Psychiatric Association that optimally a physician, preferably a psychiatrist, should provide or at least supervise psychotherapy. Under this policy—a policy which, incidentally, presently operates in several of the larger health insurance plans—a physician without training in psychiatry is recognized as a competent provider of psychotherapy; whereas a trained clinical psychologist is not, in spite of the fact that psychologists are licensed to provide psychlogical services, including psychotherapy, in 46 states and the District of Columbian. Maintenance of the undocumented position that psychotherapy is a "medical treatment" and necessitates the services of a physician produces a pseudoscarcity of manpower which in turn results in inflated cost of services. If psychotherapy were freely permitted by all qualified providers, the cost would be considerably less. Any National Health Insurance Plan which encourages the provision of psychotherapy by physicians will actually provide further incentive for the continued misuse of American psychiatrists who in spite of their expensive and highly technical medical training spend approximately 40% of their time in the office practice of psychotherapy. Consequently, public institutions across the nation are forced to rely on foreign medical graduates to provide care for the most severely mentally ill persons.

CLASS-SPECIFIC NATURE OF TRADITIONAL MENTAL HEALTH SERVICES

Utilization of mental health services varies directly with extent of education and level of income—a point which was noted as early as 1960 by the Joint Commission on Mental Health. This is a pervasive finding and it is not merely the result of financial inaccessibility. Insurance plans providing liberal mental health benefits experience the same class-selective utilization. For example, a Group Health Insurance study project on psychiatric benefits demonstrated the following findings:

(1) Families with incomes of over $10,000 used significantly more psychiatric services than those with lower incomes.

(2) White collar workers used twice as much care as blue collar workers.

(3) Salaried professionals received psychiatric benefits 8 times more often than unskilled workers.

(4) Individuals with a college degree had almost 10 times the number of office visits for psychotherapy as did those with a grade school education.

This class-specific nature of traditional psychiatric services is further illustrated by the American Psychoanalytic Association's finding that private psychoanalytic patients were 98% white and 78% college educated. This is not to say that mental health services per se are not relevant to people who have avoided traditional psychiatric services; in fact, epidemiological evidence clearly shows a greater need in this population group. It simply indicates the need for a broader range of services and service providers and a modification of existing approaches to mental health care. Miller and Riesman, authors of *Social Class and Social Policy*, have stated:

"It is becoming increasingly clear that as treatment forms and approaches are modified in terms of the needs and styles of life of low-income people, these people evidence a much greater acceptance of mental health services."

RECOMMENDATIONS

1. Legislators faced with a demand for mental health services about which there is no professional consensus will do well to rely heavily on consumers themselves in framing mental health coverage under a national health insurance plan. Consumer input concerning the type of services needed and an ongoing consumer role in monitoring such services will provide the best guarantee of responsive mental health care.

2. Coverage incentives should be designed which encourage *organized systems of mental health care* such as community mental health centers. Such incentives would facilitate service continuity and would maximize the service alternatives available to an individual.

3. If services must be restricted because of fiscal limitations, consideration should be given to establishing an annual per-capita dollar limitation within which the consumer can purchase from a wide variety of mental health services whatever combination best addresses his particular problems. It should be possible for a consumer to use his annual mental health care allocation as a capitation pre-payment for membership in an organized mental health care system.

This arrangement would encourage cost-effective service approaches and appropriate manpower utilization in a field which because of the "vagueness" of its treatment objectives is particularly subject to excessive utilization in the interest of profit.

4. Consideration should be given to establishing a form of "institutional licensure;" that is, a mechanism for licensing organized mental health programs. Licensed programs, in turn, would assume responsibility for certifying and recertifying various service providers on the basis of competency and interpersonal skills.

5. All mental health services funded under a national health insurance plan should be subject to utilization review and peer review means for monitoring duration and quality of services.

6. Finally, a form of catastrophic coverage should be extended to persons with the demonstrated chronic mental incapacity to care for themselves. Rather than paying for extended hospitalization, however, such coverage should provide for more effective service alternatives.

Mr. ROSTENKOWSKI. Thank you.

Dr. Chodoff?

STATEMENT OF PAUL CHODOFF, M.D.

Dr. CHODOFF. Mr. Chairman, I am Paul Chodoff. I am a private practicing psychiatrist in the District of Columbia area. I am a member of the advisory council of this committee. I must confess I am also a card-carrying member of the Washington Psychiatric Society, and the American Psychiatric Association which I hope will not be interpreted as a conflict of interest. I have not a statement to submit but I hope you will allow me to talk informally on a matter of somewhat peripheral concern to this meeting. That is the issue of peer review which has been alluded to by some of the previous speakers.

Their position is accepted that there should be full coverage for mental health services and I adhere to that position. It is quite clear that there are problems about cost control arising from such coverage and there also are a more fundamental set of issues about the need to monitor and prevent abuses or exploitation of public moneys.

It is through the melange of activity called peer review that the profession of psychiatry proposes to deal with these important questions. By peer and utilization review we mean mechanisms which serve to monitor claims. That is, if a third party or a carrier whether it be private or commercial or the Government, has some question about a claim, there must be a mechanism whereby this can be judged.

Also, there is a need to establish standards for the proper practice of whatever psychiatric modalities are being employed.

Thirdly peer review can be used for continuing education of the profession all in the interests of the public.

Now, I want to say briefly that the American Psychiatric Association has been extremely active in the establishment and implementation of peer review measures since 1968. Each of the district branches of the APA, about 70, has a functioning or potential peer review committee and a central APA office of peer review to monitor and serve as an information center for all these activities is now planned.

There is a great deal of theoretical and investigative work going on in various centers. Yale, Harvard, New York, to determine such things as proper lengths of stay, criteria for admissions and stays in hospitals. These can be applied also to out-patient modalities.

One very interesting project now being organized, and it's relevant to this committee's activity, is a NIMH and Civil Service Commission study of patterns of utilization in this area and two other cities covered by the Federal Employees Benefit Programs which I am sure you all know represents an experiment in full coverage of mental health needs.

There is a project with the forbidding acronym of SCOPSI. I forget what it means, but it is an attempt to make order out of the CHAMPUS mess which received congressional attention in the past year. Under a contract with NIMH, teams of consultants were put to the task of appraising some of the practices which had cost CHAMPUS a great deal of money, particularly the length of stay in residential treatment centers for children. I am told that according to the Office of Management and Budget who analyzed these figures, it cost something like $70,000, and they were able to save $7 million which attests to the value and efficacy of properly handled peer review mechanisms.

There are attempts on the part of the committees of the APA to formulate standards, called model criteria sets, so when somebody goes into the hospital a procedure will be followed by which the reason for admission will have to be justified, and the length of stay specified. If some median figure is exceeded, then the hospitalization will be reviewed by appropriate judges and only if the provisions are acceptable to them will it be continued.

Now I want to turn to my own activities, or those of the committee of which I am chairman—the Washington Psychiatric Society Peer Review Committee.

We have been functioning for about four years and clearly this is not because we are nobler and better than anybody else, we did this under the pressure of a need to respond to third party payors which have been so active in this area. As a result, we have had a very active peer review apparatus which does the various things I mentioned but is chiefly attentive to claims review. In the four years we have considered approximately 120 cases. It is not only that these cases are decided but they also serve in a case law manner as in the legal profession as guidelines for the carriers and therefore they established a body of procedure that can be followed.

Of the 120 cases we have monitored we have denied something like 20 percent which I think shows we are not a rubberstamp. We try to do an honest job in appraising cases.

Let me give a few examples of the kinds of things that we deal with. I will put these in general terms and I won't be very specific. I should say first that one of the important considerations of peer review is confidentiality and we have elaborate precautions that the confidentiality of the institution, provider and patient are all preserved.

We deal with such matters as hospitalization—is it for treatment or is it custodial and, therefore, shouldn't be paid for?

In a particular case of psychotherapy, is intensive treatment still necessary or can a less intensive form be effective?

How about group psychotherapy? Some groups need questioned as to size and purpose. How about when one patient receives many different modalities of treatment? Are they all necessary or can some be eliminated?

Are somatic treatments such as drugs and other things, being properly handled? How about the person giving the services, are they properly qualified to do so? That is another aspect of peer review.

Now, Mr. Chairman, I want to conclude by saying a little bit about the concept of accountability. This is an important value which to my mind means that if we purvey a service to the public we have to be accountable that the service is properly disbursed, that nobody is being abused and that money is being spent prudently.

As psychiatrists we accept this challenge. We are accountable to the public and we have to operate in the interests of the public. I think Mr. Chase said he believed and I guess it was implied in Dr. Taylor's testimony that organized systems do better as far as accountability is concerned. Well, that sounds true but I am not sure it is true. I have recently been involved in a study which will be published as a report of a GAP committee on the effect of methods of payments on the mental health care practices. We found somewhat surprisingly that in systems in which you get paid directly for your services and the funder wants to know what you are doing, that accountability is greater. Thus, there is more such scrutiny in private practice under third party influence than in the community mental health centers which have been put forth as a model of accountability. However, accountability is a value which all who practice psychiatry must take seriously and must do their best job in implementing.

Thank you.

Mr. Rostenkowski. Thank you, Doctor.

Dr. Keisler?

STATEMENT OF CHARLES A. KIESLER, PH. D., ACCOMPANIED BY HERBERT DORKEN, PH. D., AND CLARENCE J. MARTIN

Dr. Kiesler. Mr. Chairman, members of the committee, I am Dr. Charles Kiesler, executive officer of the American Psychological Association. I am here today representing the APA and our sister institution the Association for the Advancement of Psychology. At my left is Dr. Herbert Dorken of the Langley-Porter Neuropsychiatric Institute in San Francisco, who is the chairman of APA's Committee on Health Insurance.

To his left is Mr. Clarence Martin, executive director and general counsel of the Association for the Advancement of Psychology.

Mr. Chairman, we appreciate the opportunity to submit both a written and oral statement as a participant on this panel and I believe the committee will find our written statement to be fairly comprehensive. We would, therefore, like to confine our oral testimony to a summary of issues involving costs and mental health benefits in a national insurance program. We have three points to make in that regard:

1. Any comprehensive national health insurance plan can afford the expenditure of the reasonable percentage of total health funds involved in the coverage of mental and emotional disorder.
2. The cost of mental health services can be controlled with properly planned coverage and appropriate access to psychologists and psychiatrists in a comprehensive, integrated plan.

3. There is good evidence that appropriate utilization of mental health services may actually drive down the utilization and cost of other health services with a possible net savings in the entire health insurance plan.

Any examination of the costs of mental health services must begin with the examination of the incidence of mental health problems. From time to time we hear offhand estimates of the incidence of mental illness ranging upwards from 50 percent of the population. Indeed, in times of national tragedy, we have been told that the whole society is "sick." To be sure, we may all have problems, but mental health is not the absence of problems, it is the ability to deal with problems. When we talk about the incidence of mental health problems, we are talking about that percentage of the population that at one time or another can no longer adequately cope with their daily lives. The most accepted surface epidemiological estimates of the incidence of such problems in this country range from 10 to 20 percent. In a recent paper, Dr. Morton Kramer, Director of the Division of Biometry of the National Institute of Mental Health, in hypothesizing varying levels of need uses 20 percent as an outside estimate. The entire population at risk, then, for mental health coverage reaches, at the outside, no more than 20 percent of the population.

It is perhaps a sad commentary that estimated accidents and actual patient care are two grossly different matters. Kramer's data shows that in 1971 actual reported patient-care episodes were just less than 2 percent of the population, a conservative estimate. From the available data one can liberally assume that in the United States today 8 to 10 million persons, or less than 5 percent of the population, are currently using some form of mental health services.

Looking at actual patient care from a purely dollar standpoint, what has been the experience of private health insurance plans currently offering mental and nervous disorder coverage? The answer is mixed. Some plans offer extensive benefits and employ few controls. Others have more limited coverage. Also, as the subscriber population varies, the use of mental health benefits varies, as has been mentioned. As we go down the socioeconomic ladder, mental health benefits are used less. CHAMPUS, the Civilian Health and Medical Plan of the Uniformed Services, is the largest group plan in the United States and offers virtually unlimited mental health coverage. They report that such coverage accounts for 12.8 percent of their total dollars paid for all health services, with well over 50 percent of that for hospitalization. Blue Cross-Blue Shield reports about 7 percent with less spent for hospitalization for its Federal Employees Health Benefits Plan. Other policies with different subscriber populations report lower percentages. The evidence would lead us to believe that there are identifiable factors which account for these variations. That means that in a well planned program mental health costs can be controlled while the program offers effective service of clearly delineated mental and emotional disorder.

This committee is undoubtedly inundated with statistics on health care costs, but we estimate we are spending approximately $3 billion annually for diagnosis and treatment of mental and emotional disorder. Compare that $3 billion to the 8.3 percent of our trillion dollar Gross national Product that the Nation now spends for health care.

Compare that $3 billion to the $28.6 billion the Federal Government alone spent for direct health services just last year. Mr. Chairman, we believe the coverage of mental and nervous disorder under a comprehensive national health insurance plan constitutes a reasonable expenditure of health funds.

I said earlier that by including mental health services in a well planned and integrated program with proper access to mental health professionals, we may be able to drive down total health care costs in national health insurance.

How can that be?

The evidence shows that many physical complaints of patients, while very real, arise from mental and emotional distress and are only efficiently treated with mental health services. Early and open access to such services can eliminate a great deal of unproductive and expensive diagnostic work, can reduce hospitalization, and generally result in dramatic savings in the short run and even more dramatic savings in the long run.

William Follette, chief psychiatrist, and Nicholas A. Cummings, chief psychologist, both of the Kaiser Foundation Hospital and the Permanente Medical Group of San Francisco, Calif., have recently completed a study, as yet unpublished, on utilization of mental health services in the Kaiser experience. The conclusions from their 8-year study are as follows, and I quote:

> Persons in emotional distress were significantly higher users of both in-patient and out-patient medical facilities as compared to the health plan average; there were significant declines in medical utilization in those emotionally distressed individuals who received psychotherapy as compared to a control group of matched emotionally distressed health plan members who were not accorded psychotherapy; these declines remained constant during the five years following the termination of psychotherapy.
>
> Sixteen years of prepayment experience demonstrates that there is no basis for the fear that an increased demand for psychotherpay will financially endanger the system, for it is not the number of referrals received that will drive costs up, but the manner in which psychotherapy services are delivered that determines optimal-therapeutic effectiveness. The finding that one session only, with no repeated psychological visits, could reduce medical utilization by 60 percent over the following five years, was surprising and totally unexpected. Equally surprising was the 75 percent reduction in medical utilization over a 5-year period in those patients initially receiving brief therapy in psychotherapy sessions. The clinic procedures was to offer early and incisive intervention into the patient's crisis problem, get beneath the manifest symptoms to his/her real concerns and offer understanding and therapy within the first session itself.

Let me note here parenthetically that these reports do show that people go to general physicians with mental health problems, and that these people, not trained to handle such problems, do not really help. That is, the patient continues to come back without relief, and when they take advantage of available psychotherapy, the visits to general practitioners decrease.

In effect we are saying that treatment of mental health problems will occur in any national health plan. The question that we are here for is whether the people who are trained to handle it will be in the plan. People do use untrained people for such problems and they are ineffective.

Other studies have indicated that if appropriate recognition of mental conditions is made, medical utilization by the individuals can be reduced by as much as one-third, offsetting the cost of mental diagnosis and treatment. In one of the few studies in an industrial setting (Kennecott Copper, Utah), access to mental health and counseling services showed a before and after reduction of hospital and medical-surgical costs of 55 percent and reduction in absenteeism of 52 percent for the treated employee. A comparable control group showed no favorable change over time.

Mr. Chairman, what does this all tell us? It tells us that mental health services in a comprehensive national health insurance plan will account for a reasonable percentage of the total costs or approximately $3 billion. It tells us that mental health services in such a plan may actually reduce the total cost of the plan. And it tells us that mental health costs can be controlled in a properly planned and integrated program with proper access to such services. And it tells us that mental health services in national health insurance could conceivably reduce the total cost of that plan. But there are a lot of things that it doesn't tell us. There is a lot we just don't know.

Any legislation on national health insurance coming out of this Congress would be wise to include generous funding for on-sight research and development of mental health services in the total health care system. Studies like the ones at Kaiser and Kennecott Copper show that there are psychological variables in much of what has been thought to be purely medical. We need to know more about that. Our figures show that differently designed programs yield different costs for mental health coverage, and we need to know something about that. We do have somewhat of a handle on cost effectiveness, but there is a great deal more we could learn. PSRO will come a long way in providing many answers, but other specific evaluation programs outside of PSRO will be necessary as well.

And I should add that psychologists in general and the APA in particular support an effective and continuing evaluation of all national programs, and specifically physical health as well as mental health. So we are being entirely consistent in this regard.

Mr. Chairman, we wish to thank the committee for the opportunity to make this presentation. We have covered only one of many issues involved in deliberation over the inclusion of mental health benefits in a national health insurance plan. We believe that our written testimony addresses this and many of the other issues in greater detail. We hope that the members of the committee will find time to give that written statement some consideration.

Thank you, Mr. Chairman.

Mr. ROSTENKOWSKI. Your entire written statement will be placed in the record. Dr. Kiesler.

[The prepared statement follows:]

STATEMENT OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION, THE COUNCIL FOR THE ADVANCEMENT OF THE PSYCHOLOGICAL PROFESSIONS AND SCIENCES, AND THE ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOLOGY

SUMMARY

Mr. Chairman, our testimony today may be summarized by these statements.

1. Those disorders and dysfunctions generally referred to as mental illness constitute a major health problem and should be covered on a parity with physical illness under National Health Insurance.
2. Costs of mental health services are not unreasonable.

3. Utilization of mental health services is controllable.

4. Utilization of mental health services tend to lower medical, surgical and laboratory diagnostic costs of users.

5. A state level Professional Standards Review Committee fashioned along lines of the federal PSRO is one of several mechanisms available to control quality and cost of psychological services in 50 states and D.C.

6. Providers of mental health services are in short supply.

7. Psychologists, especially trained, duly licensed, geographically well distributed and accepted as qualified health providers by both public and private insurance carriers should be recognized under National Health Insurance Plans.

STATEMENT

Mr. Chairman, members of the Health Subcommittee of the Committee on Ways and Means, I am Charles Kiesler, Ph. D., a psychologist and Executive Officer of the American Psychological Association. I am accompanied here today by Herbert Dorken, Ph. D., a psychologist with the Langley Porter Neuropsychiatric Institute at the University of California system in San Francisco and currently chair of the APA's Committee on Health Insurance; and Clarence Martin, Executive Director and General Counsel of our sister organization, the Association for the Advancement of Psychology.

Mr. Chairman, the Board of Directors of the American Psychological Association adopted in July 1971 a position statement on National Health Care. These principles remain valid and I would like to take this opportunity to restate them.

"1. All persons should have equal access to all health services, regardless of the ability to pay or of other circumstances such as geographical location.

2. The health care system should protect the individual's rights in regard to human dignity, privacy, and confidentiality.

3. Funding of the system should provide for each of the following: (a) direct services for both prevention and treatment of physical and mental illness; (b) a full range of health manpower, including necessary training and upgrading of health care personnel at all levels; (c) research into the causes of illness and its treatment; (d) public education and other population-oriented programs of prevention.

4. The health care system should permit the individual freedom of choice among the full range of health services and providers of these services.

5. Consumers, as well as providers of health services, should have an opportunity to participate in the development of the health care system.

6. Redress for grievances resulting from the providing of personal health services should be available from review bodies which include both consumers and health professionals.

7. The quality and availability of health services should be evaluated continuously by both consumers and health professionals. Research into the efficiency and effectiveness of the system should be conducted both internally and under independent auspices.

8. The system of health care should be responsive to the findings of review bodies, to the results of research, and to emergence of new concepts of service." [1]

Since the adoption of those principles, much has happened in the field of health which reinforces the need for a national health system.

Total federal expenditures for personal health services have increased 86 percent to an estimated $28.6 billion for fiscal 1975.

The nation is now spending 8.3 percent of the total value of the goods and services it produces for health care.

Our national health statistics, however, remain poor in comparison with other industrial nations.

The members of this Committee and its predecessor committees in past Congresses have heard testimony on scores of health care bills.

The problems raised by these bills are many and the solutions offered by the hundreds of witnesses are often conflicting, seemingly irreconcilable or just down right too expensive.

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[1] Adopted as a position statement of the American Psychological Association by its Board of Directors on July 8, 1971. Based on a report of the Task Force on National Health Care (Victor Raimy, Chairman; Andie L. Knutson; William Schofield; S. Don Schultz; and Milton Theaman); John J. McMillan (Staff Liaison) and Jack G. Wiggins (Liaison from the Committee on Health Insurance); and the Board of Professional Affairs.

No one at this moment knows what an ideal health system will look like. We can probably reach a consensus, however, on what that ideal system should achieve. It should achieve a long productive life, minimal illness and disability, effective treatment of unavoidable trauma and disease, rapid restoration of optimal functioning following disability, humane treatment, equitable access to quality care; *and* at a cost that permits the realization individually and governmentally of other desirable social and personal goals.

I would like, Mr. Chairman, to address myself to several items which I hope go to specific concerns of this Committee, the interest of the public and the potential contribution of American psychology.

The Committee must be concerned not only with the need for a service but with the cost. Health benefits must be paid for and we must all be concerned with cost both as taxpayers and as responsible citizens.

There is ample reason to urge that mental health problems be a major concern of national health programming. Mental health problems are debilitating and often seriously impair or prevent employment. They can and do lead to physical illness. They place inordinate demands on the time of medical practitioners not equipped by training to cope with them. Data indicates that psychological disorders are frequently the factors precipitating a visit to a physician.

Reasonable mental health benefits, provided by qualified, experienced mental health practitioners including psychiatrists and psychologists will reduce the per capita cost of health care.

The availability and provision of mental health services have been shown through research to reduce dramatically the extent of subsequent use of surgical, in-hospital and diagnostic laboratory services.

From the available data it appears that there are in the United States somewhere between 8 million and 10 million persons presently utilizing mental health services.

It is further estimated that an additional unmet need exists for 11 to 16 million individuals.

Even if the incidences of need remain constant and increases only proportionate to population increases are projected, an additional number will come in need each year. Kramer's data does show that patient care episodes increased from .63% of the population in 1946 to 1.03% in 1955, 1.2% in 1963 and 1.99% in 1971. Utilization of mental hospitals during this period declined from 61% in 1955 to 25% of the reported episodes in 1971. Outpatient clinics and community health centers accounted for 61% of the episodes.[2]

An increase in total episodes as well as greater utilization of outpatient treatment argue the necessity of a health policy which not only covers mental treatment in hospitals and other institutional settings, but in outpatient facilities and private office settings as well.

We strongly support the concept that defined mental health impairment, clearly delineated, should be included under National Health Insurance. We recognize also that it would be inappropriate and clearly impractical to try to include all human ills, mental or physical, under National Health Insurance. Limitations of treatment methods and utilization review of accepted treatments are necessary and proper in a NHI scheme.

Recent developments in the treatment of mental health problems have focused on the concept of individualized treatment plans for every patient. The individualized treatment plans include the nature of the problem, the goals for treatment, and the steps or procedures to be taken to meet those goals. It is no longer acceptable to simply state that a patient is under treatment. Every patient should have an individualized written treatment plan based on an assessment plan derived from diagnostic procedures developed along proven psychological principles. One of the great advantages of such a treatment plan is that it provides careful monitoring of the effectiveness of the treatment provided to each patient. It also provides for very careful control of the kind and amount of treatment provided. Individualized treatment plans are now required for meeting accreditation standards and have been required by court action.

Psychologists have pioneered in the development of specific treatment plans. The psychologist's basic orientation in the behavioral sciences with a special focus on mental health has encouraged psychologists to carefully monitor their treatment approaches. Psychologists were involved in setting up behavioral or measurable objectives to treatment plans for some time. This very special orientation of the psychologist in the treatment of mental health problems permits not only careful monitoring of the treatment approaches but also effective evaluation of the outcomes of those approaches. With individualized written treatment plans which include objectives it is possible to determine to what extent the treatment plans are succeeding. Rather than maintaining a treatment approach which would not lead to changes, this system of individualized treatment plans permits the changing of treatment strategies to meet individualized patient needs. It also tends to maximize the treatment given by any therapist for any patient. This procedure has now been incorporated in the Standards for Providers of Psychological Services adopted by the American Psychological Association.

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[2] Kramer, M., Division of Biometry NIMH "Issues in the Development of Statistical and Epidemological Data for Mental Health Services Research" 1974.

LIMITATIONS OF TREATMENT

One of the significant concerns raised in any discussion of National Health Insurance coverage for mental health services involves the possibility of coverages for a range of treatment approaches some of which may not be standard or acceptable treatment methods. There have been in the mental health field innovative treatment approaches, some of which are clearly in the experimental stage and many of which may never achieve acceptance by the majority of the profession and would therefore never become acceptable standard procedures of the profession. It is critical that any National Health Insurance plan provide adequate coverage for the treatment procedures which have become acceptable, reasonable treatment methods meeting the standards of practice and ethics of the profession.

There are several controls and restrictions in this regard which should be pointed out. The training programs for clinical and counseling psychologists which exist in the major universities and hospitals throughout the country receive approval or accreditation by the American Psychological Association after careful review of all components of those programs. The accreditation process by the American Psychological Association assures a very significant degree of control over the nature and quality of training programs for the future health service providers in psychology. The accreditation system provides reasonable and acceptable standards for insuring that the training of health service providers in psychology includes the standard and well-founded psychological principles and techniques which have proven useful in the mental health field.

Another aspect of the profession's concern with reasonable acceptable treatment procedures are the established Standards for Providers of Psychological Services, the Code of Ethics and Professional Conduct, and other professionally designed control systems.

Psychology's peer review programs now in effect in all 50 states, provide perhaps the most significant control in this area. Peer review organizations have already proven extremely useful in providing the appropriate checks and balances to treatment approaches by mental health professionals. Given the current organization in all the states and the early successes of the peer review system, it is anticipated that the peer review experiences will provide an efficient and reasonable method of monitoring treatment approaches as well as insuring the best service available to every individual patient.

FOCUS OF TREATMENT

The focus of the mental health coverage should be on the impairment of the individual rather than on any specific treatment approach. That is, coverages should be identified by the nature of impairment with the specific treatment plan to be determined by the individualized problem and treatment plan. One of the great problems in the mental health field is that some individuals will identify almost anything as being a reasonable psychological or mental health problem and therefore the cost projections become astronomical. This is clearly a distortion. The most accepted epidemiological estimates of the incidence of mental health problems in this country range around 10 to 20%. This is the percentage of individuals identified as being impaired in some fashion in their coping and requiring some kind of treatment. The population at risk then, for mental health insurance reaches a maximum of approximately 20%. Moreover, many of the problems which may be identified as mental health problems have in the past and continue to be seen by the general medical practice field. That is, there are existing mental health services which are being provided by health programs not necessarily identified as mental health. A large portion of a pediatrician's work for example, consists of dealing with a range of developmental, behavioral, and other mental health problems of the infant.

The recent experience of insurance firms in the coverage of mental health problems provides good data for delineating those services which should be reimbursable. It has become very obvious that it is possible to identify those services which should be reimbursable and to eliminate those which should not be reimbursable. The great concern of unlimited coverage for a range of human condition problems has been solved and control methods exist. We will cite specific examples under the cost and utilization material later in this testimony.

WHO TREATS MENTAL ILLNESS

The number of psychologists and psychiatrists providing health services are about evenly divided. Most providers in both professions function in multiple delivery systems as well as in teaching, hospital and outpatient services. Psychologists are better distributed geographically than psychiatrists and there is a consistent trend towards recognition of psychologists as primary health providers in private insurance contracts and state and federal programs.

Estimates of total professional manpower in health delivery services by psychologists and psychiatrists have been estimated by DHEW as 28,332 physicians specializing in Psychiatry or Neurology (1972) and 26,927 psychologists (1970) in health providing services of some kind on a part or full time basis.

An American Psychological Association study in 1972 reported the following findings for psychologists in health delivery settings: 36% identified themselves as clinical psychologists; 19% were employed in hospital settings; 6% in medical schools. and 15% in clinics; 8% of the clinical psychologists were engaged in research and 13% were engaged in management or administration. Only 2% were foreign trained.

Psychologists practice in nearly all health care settings, with frequency of practice being approximately equally distributed among private practice, outpatient clinic, and hospital based practice. In hospitals, psychologists may be on the professional staff or the affiliate staff or on the hospital salary payroll. Psychologists are part of most Health Maintenance Organizations, and are involved in most Community Mental Health Centers, sometimes as program directors. They less commonly practice in Foundations for Medical Care, although they are included in such Foundations in several states. In California, recent legislation provides that in Health Maintenance Organizations offering mental health services, the star shall include both psychologists and psychiatrist and the consumer shall have personal choice and direct access to either provided.

Psychologists are on the staffs of all accredited Medical Schools in the United States, and will typically have clinical as well as teaching and research responsibilities in such facilities.

Fee or funding arrangements for psychological services are quite varied, being rather evenly divided between fee-for-service charges and indirect charges included under hospital costs or similar organized health settings. The fee-for-service billing by the psychologist is the most common practice for licensed psychologists functioning as independent professionals, and is probably the least expensive to the consumer in the long run. because it does not include capital cost, overhead and other indirect expenses of an intermediary institution or professional referral.

Recognition of psychologists as independent qualified mental health service providers has recently been reflected by HEW spokesmen:

"The tradition that all service must be provided by a physician or under his guidance is now giving way to practical reality. As an example of this trend, as of January 1, 1975, all government employees' insurance plans will permit payments to psychologists, without requiring a physician's supervision. This more practical attitude should be encouraged by all of us." [3]

A number of other federal and state programs recognize psychologists as primary health providers.

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[3] Address by Charles C. Edwards, M.D., Assistant Secretary for Health, U.S. Department of Health, Education and Welfare to the ADAMHA Annual Conference of the State and Territorial Mental Health, Alcohol, and Drug Abuse Authorities, Washington, D.C. on November 21, 1974. The reference is to the McGee-Waldie Act (S2619/HR9440) which became P.L. 93–363 on July 30, 1974.

The Rehabilitation Act of 1973—Public Law 93–112—recognizes psychologists who are licensed/certified according to State statute, along with physicians, for diagnostic and restorative services to beneficiaries.

CHAMPUS recognizes the autonomous practice of clinical psychology in its nationwide health benefits program which covers dependents of military personnel, retired military personnel, and other beneficiaries.

CHAMVA is a new program for disabled veterans which recognizes psychologists as autonomous practitioners.

Community Mental Health Centers regulations provide that psychologists may serve as program directors.

Veterans Administration provides that directors of VA mental hygiene clinics may be qualified psychologists or other mental health professionals who will be responsible for the formation and general supervision of administrative activities inherent in the professional programs of the clinic.

Veterans Administration regulations provide that psychologists and other health professionals licensed/certified by the State may provide services on a fee basis to out-patients through VA clinics.

The Work Incentive Program (WIN) accepts professional evaluations by licensed/certified psychologists as well as physicians, as to evidence of determinable mental impairment.

Work Injuries Compensation of Federal Employees coverage has been broadened so that the definitions of "physician" and "medical, surgical and hospital services and supplies" include clinical psychologists. (Public Law 93–416).

The Social Security Bureau of Disability Insurance accepts the reports of psychologists without physician referral or endorsement as evidence of disability for social security benefits.

Health Maintenance Organization legislation (Public Law 93–222) includes clinical psychologists among providers of services.

Department of Defense includes psychologists in its policy which provides that "any qualified health professional may command or exercise administrative direction of a military health care facility . . . without regard to the officer's basic health profession."

Some major health-insurance carriers have recognized the disadvantages of mandatory medical referral/supervision and have voluntarily included psychologists as autonomous providers of services in many of their contracts. These firms include, but are not limited to Aetna, Guardian, Liberty Mutual, Massachusetts Mutual, Occidental, Prudential, Travelers, and Teachers Insurance and Annuity Association (TIAA).

At this writing twenty-three states and the District of Columbia have enacted legislation requiring private major medical health insurance plans to make direct payments to psychologists in the same manner as payments are made to physicians without prior referral or supervision in plans providing mental health coverage:

Arkansas
California
Colorado
Kansas
Louisiana
Maryland
Massachusetts
Michigan
Mississippi
Montana
Nebraska
New Jersey
New York
Ohio
Oklahoma
Tennessee
Utah
Virginia
Washington
Oregon
Connecticut
Minnesota
Maine

Fifteen states give this kind of independent provider recognition to psychologists under their state Medicaid plans:

California
Connecticut
Hawaii
Maine
Minnesota
Montana
New Hampshire
New Jersey
New Mexico
New York
(except New York City)
Ohio
Oklahoma
Oregon
Tennessee
Utah

The geographical distribution of psychology's service providers does not differ significantly by region from the 1970 population census:

"Psychologist service providers are distributed throughout the United States in approximately the same way that the total population of consumers of psychological services are distributed.

Geographic maldistribution, at least regionally, apparently does not apply to psychologists."[4]

An in depth study of geographical distribution in one state is the 1974 *Ohio* study by James T. Webb, Ph.D., *Ohio Psychologist,* (July 1974), XX, 4, 5–12, copies of which were submitted to this committee by us on April 15, 1975 and September 26, 1975.

UTILIZATION AND COST

At the present time, it has been estimated that in the United States we are spending around $3 billion a year for the diagnoses and treatment of mental conditions. The cost of undiagnosed, untreated conditions has been estimated at $24 billion annually, including $10 billion in lost wages, $2 billion in lost taxes, $2 billion in the transfer of spendable income and $10 billion in improper diagnosis and ineffective treatment. The cost of untreated mental conditions is eight times the costs of direct services.

William Follette, chief psychiatrist, and Nicholas A. Cummings, chief psychologist, both of the Kaiser Foundation Hospital and the Permanente Medical Group of San Francisco, California, have recently completed a study, yet unpublished, on utilization of psychological services in the Kaiser experience.[5]

The Kaiser Foundation Health Plan in the Northern California Region is a group-practice prepayment plan, offering comprehensive hospital and professional services on a direct service basis. The composition of the subscribers is diverse, encompassing most socio-economic groups. During the period of the study, the psychiatric clinical staff in San Francisco consisted of psychiatrists, clinical psychologists and other mental health service providers. Their eight year follow up of the program produces the following conclusions:

Persons in emotional distress were significantly higher users of both inpatient and outpatient medical facilities as compared to the Health Plan average;

There were significant declines in medical utilization in those emotionally distressed individuals who received psychotherapy as compared to a control group of matched emotionally distressed Health Plan members who were not accorded psychotherapy;

These declines remained constant during the five years following the termination of psychotherapy;

The most significant declines occurred in the second year after the initial interview, and those patients receiving one session only or brief psychotherapy (two to eight sessions) did not require additional psychotherapy to maintain the lower level of utilization for five years;

Patients seen two years or more in regular psychotherapy demonstrated no over-all decline in total outpatient utilization inasmuch as psychotherapy visits tended to supplant medical visits. However, there was significant decline in inpatient utilization in this long-term therapy group from an initial hospitalization rate several times of the Health Plan average, to a level comparable to that of the general adult Health Plan population;

During the entire period of the study, as well as in the insured years before and after the eight years of this study, the utilization of mental health services was consistently for inpatient (hospitalization) one-half per thousand insured, and nine per thousand insureds for outpatient services. The average length of hospitalization remained under eight days, and the average outpatient psychotherapy series remained at 6.6 visits;

Sixteen years of prepayment experience demonstrates that there is no basis for the fear that an increased demand for psychotherapy will financially endanger the system, for it is not the number of referrals received that will drive costs up, but the manner in which psychotherapy services are delivered that determines optimal cost-therapeutic effectiveness. The finding that one session only, with no repeated psychological visits could reduce medical utilization by 60% over the following five years, was surprising and totally unexpected. Equally surprising was the 75% reduction in medical utilization over a five-year period in those patients initially receiving two to eight psychotherapy sessions (brief therapy). The clinic procedure was to offer early and incisive intervention into the patient's crises problem, get beneath the manifest symptoms to his/her real concerns and offer understanding and therapy within the very first session itself.

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[4] Whiting, J. F., Dorken, H., Psychologists as Health Service Providers, *Professional Psyychology* (1974, Aug.), pp. 309–319.

[5] Cummings, N. and Follette, W., "Brief Psychotherapy and Medical Utilization: An 8 Year Follow Up." Chapter 10 in "The Professional Psychologist Today; New Developments in Law, Health Insurance and Health Practice," Dorken, H. and Assoc. Ed. Pub. Jossey-Bass (in press 1975).

We can, as a nation, invest more monies on direct services for mental conditions and, at the same time, obtain significant savings in tax monies, prevent loss of money to employers and employees alike while promoting human welfare! Reasonable mental diagnosis and treatment can be made available to all citizens for a reasonably low cost, and the costs of treating these mental conditions will be offset by substantial reductions in the costs of other health services.

Review of the literature shows that mental conditions can reduce efficiency on the job by 20%, tend to increase absenteeism significantly, result in the higher use of medical benefits and spuriously inflate the cost of health insurance contracts provided by employers. It has also been found that mental conditions result in under-employment and, with appropriate intervention and treatment, individuals with mental conditions can be rehabilitated into productive lives in which their incomes produce new tax money, off-setting the cost of treatment and reducing their burden to welfare rolls and state hospital systems.

When comparing the cost of treatment for mental conditions, it becomes evident that psychological therapy is the treatment of choice in the large majority of cases, with drug therapy running a second choice and hospitalization a third. However, the utilization of mental health services currently measured by dollar costs is just the reverse. Hospitalization tends to be over-utilized and could be reduced by one-third. Medication where prescribed, may be used ineffectively and frequently avoids getting down to the basic problem, which can be uncovered through psychotherapy. Psychotherapy, though a costly procedure, is an insurable benefit and, in the final analysis, appears to be a most effective way of intervening into mental behavioral conditions.

Failure to diagnose and treat mental conditions puts an undue burden on the delivery of other health services. There is general agreement that about 60% of the patients going to family doctors' offices for physical symptoms have a psychological problem which is either a primary problem or aggravates the physical conditions or interferes with effective treatment regimens.

Studies also indicate that high users of medical services are frequently emotionally disturbed, often suffering from mental depression. Other studies indicate that if appropriate recognition of mental conditions is made, medical utilization by these individuals can be reduced by as much as one-third, off-setting the cost of mental diagnosis and treatment. Studies further reveal that the general practice physician himself frequently does not recognize mental conditions, and, if he does, he may not know how to treat or how to refer the patient for appropriate help.

In one of the few studies in an industrial setting (Kennecott Copper, Utah), access to mental health and counseling services showed a before and after reduction of hospital and medical-surgical costs (55%) and absenteeism (52%) for the treated employee. A comparable control group showed no favorable change over time.

Other sets of data indicate that with appropriate treatment, people with mental conditions, including the mentally retarded, can become gainfully employed, increase their incomes, improve their job efficiency, reduce sick time and absenteeism from the job. The cost of direct services for mental conditions can be offset by new tax monies on increased earnings to these individuals.

The cost of training the necessary manpower, the making of manpower available to various segments of the population, and the cost of needed research must be borne in mind in calculating the cost of services. However, comparing the cost of mental health manpower with the cost of training physician specialists reveals that it is cheaper to train mental health specialists and have them deal with the mental conditions at the earliest entry point into the health system. Reliance upon he primary physician as a referral source for mental conditions is not only a costly, but an inefficient way to get people into treatment.

Costs of mental health benefits under various insurance programs have been surveyed by a number of sources.

As the single largest group health plan in the United States, as well as a plan with virtually unlimited mental disorder insurance, the experience of the Civilian Health and Medical Plan of the Uniformed Services should be of particular interest.

Dorken's[6] study of the CHAMPUS experience in those 10 states which constitute the concentrated use of CHAMPUS in FY 1973 reveals a great deal of information relatable to National Health Insurance.

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[6] Dorken, H., "CHAMPUS Ten State Claim Experience for Mental Disorder FY 1973." Paper presented to American Psychological Convention, New Orleans, 1974.

The benefits available under CHAMPUS in 1973 for mental disorder were almost unlimited. In the 10 states studied, the insured population under CHAMPUS consisted of 3.26 million individuals. Mental disorder utilization of the benefits consisted of 1.87% of the insured. Total cost per user averaged $1,138 (government cost $929) in the year.

On a per capita basis these extensive mental health services were at an annual cost of $19.82 (CHAMPUS cost $16.15 or on a monthly basis, $1.35) per capita.

The total mental health services absorbed 12.8% of the total health benefit funds before any adjustment for the savings they afforded from the decrease in utilization of physical health benefits, such as have been demonstrated in every program tracing the adjusted cost of mental health benefits.

Of the unadjusted 12.8%, 58% was expended for hospital services, 30.5% for outpatient visits (all procedures, all professions). Of the outpatient visits, 46% were to psychiatrists, 23% psychologists, 10% social workers, 2% attending physicians, and the 19% balance distributed among all other therapists and clinics.

The unadjusted percentage of the total health benefit funds utilized by CHAMPUS is nearly twice as high as most plans report. This is probably due to two factors, the nearly unlimited extent of the benefits and the special make-up of the patient population.

The 1974 hearings before the Senate Post Office and Cvil Service Committee on the 1973 Federal Employees Health Benefit Act found Blue Cross and Aetna reporting much lower figures. Policies under these two plans provide coverage for about 80% of the insured under FEHBA. Aetna reported a mental disorder utilization experience of 1.2% and the Blues reported 1.1%.

Mental disorder cost for Blue Shield-Blue Cross represented an unadjusted 7.3% of total claims and have for several years remained in the 7% range. The plans cover over 5 million beneficiaries and based on the 1972 utilization rates for mental health services, 65% of which were utilized by hospitalized inpatients, show a cost of $11.92 per covered person (or less than one dollar a month).

In 1971 Aetna cost allocated 8.6% to mental disorder coverage; and in 1972, with psychologists recognized directly, without physician referral, the cost dropped to 8.5%.

Clearly, there is variance in utilization among age groups, sex, type of employment, socio-economic level, and type of insurance coverage available. Such variance notwithstanding, the growing body of reports, make it evident that meaningful mental health benefits are well within feasible fiscal limits. Indeed, there is some evidence, particularly from service in organized settings that the provision of mental health services can reduce other health plan utilization. These findings speak clearly to the need for comprehensive health benefits with continuity of care and incentives to community based alternatives to hospital care.

Spiro (*Am. J. Pub. Health*, 1975, 65, 139–43) compared fee service to cost financing in a union program and found that over the four-year period only 2.73% of the population at risk used mental health benefits. Utilization never exceeded 1.3% per year. Cost remained well under 50 cents per month per capita. "The removal of restrictive deductibles and early co-insurance produced none of the predicted dire effects." Hospitalization was found to be substantially higher in fee service clients. Removing barriers to hosptialization while placing restrictions on outpatient care, is a good way to run program costs up.

Scheidmandel summarized considerable utilization experience (*Psychiatric Annals*, 1974, 4, 58–74). She notes that all the group practice plans have much lower rates of hospital admissions and days of care than do fee service plans. Of plans reporting office visits, these ranged from an average of 4 to 15 per patient. Less than 10% of patients had more than 20 visits to a psychiatrist in a year.

Cohen and Hunter (*Am. J. Orthopsychiatry*, 1972, 42, 146–53) compared a fee service indemnity coverage to a community mental health center (CMHC) for retail clerk union groups in Los Angeles over a seven year period intended to provide saturation level services. Different patterns of utilization were apparent. Inpatient services accounted for 33% of costs in the Merged Trust Indemnity Plan, 8% at the center though overall utilization was higher 1.6% vs. 5.6%. The greater utilization through the center yielded higher costs but a lower cost per user, $345 vs. $245. It is concluded that hospitalization can only be avoided when community services are available in meaningful quantity unless the community is to become a dumping ground for hospitalized patients.

Mendel (American Psychiatric Association Convention, 1973) reported on prepaid experience with 6,000 welfare patients in Southern California. Utilization averaged 5.8% of the population with only one case hospitalized. The psychiatric care cost 41 cents per member per month. The importance of this study is that it contradicts the conventional wisdom that the indigent population is a higher risk for coverage than the employed.

Substantial evidence indicates that utilization of mental health benefits do not produce an unwarranted demand for services that will financially endanger a health insurance program.

The utilization of mental health benefits reduces medical and surgical utilization of the program and early availability of mental health treatment in outpatient facilities reduces the utilization of high cost institutional care.

QUALITY OF SERVICE

Psychologists are licensed or certified by statute in 47 states and the District of Columbia. The three states without statutes (Missouri, Vermont, and South Dakota) presently have legislation pending.

The standard for licensing developed by the American Psychological Association consists of a doctoral degree, a comprehensive written and oral standard examination, as well as supervised experience.

The Council for the National Register of Health Service Providers in Psychology was established at the request of the Board of Directors of the American Psychological Association to the American Board of Professional Psychology. The National Register of Health Service Providers in Psychology, a voluntary listing, is designed to identify psychologists who are licensed or certified to practice in their states *and* who are *health service providers.* Though only recently published, the Register has already been adapted by Blue Cross-Blue Shield for its governmentwide federal employee plan.

Certification or licensure of psychologists under state law is not by specialty designation per se, no more than are psysicians, dentists or lawyers licensed by specialty practice under their applicable state laws. The Register is designed to complement such statutes by identifying those licensed/certified psychologists who are health service providers.

The Council for the National Register has developed a very careful review process to assure that psychologists who are included in the Register will have had the minimum training and experience in the health services field. Specifically, to be included in the Register, the psychologists must have a *doctorate degree from an accredited university* (except for a few who have many years of practice and have been licensed at other academic levels) and must be *licensed or certified by the Boards of Examiners of Psychology* at the independent practice level in their states or the District of Columbia, and have a *minimum of two years of supervised health service experience.*

The Council for the National Register was established in recognition of the need for the development of a system by which various governmental, health services, other organizations, and individual consumers can identify psychologists who meet the *standards of practice in their states and who have training and experience in the health services field.* The National Register, working closely with the statutory State Boards of Examiners of Psychologists throughout the country and with other public and professional organizations identify psychologists who maintain the standards of their profession through state licensing and certification, and who are trained and experienced in the delivery of health services.

The first *National Register of Health Service Providers in Psychology* was published in July of 1975. This Register identifies psychologists throughout the country who meet the above-mentioned standards, assures the public, government agencies, and others that the persons included meet the criteria established by the Council for the National Register, based on the professional Standards of the American Psychological Association. The Register and supplement list approximately 7,500 licensed psychologists who meet the criteria of health service provider.

There are other safeguards within the profession of psychology to insure responsible professional service.

For twenty years the American Psychological Association with its affiliated state organizations has operated a system enforcing its Code of Ethical Conduct.

Organized psychology is developing a system of Professional Standards Review Committees at the Federal PSRO system, to review the quality, cost, and appropriateness of service beyond the strictures of ethical conduct. This system is currently operational in all fifty states and the District of Columbia, and even at this early stage in its development, it is obvious that it is very effective in identifying and controlling excessive cost, over-utilization and questionable practices. It has also proved helpful in verifying the utility of conventional and innovative therapeutic techniques.

Psychology believes that peer review is an absolute necessity in the continuing development of mental health services as well as in insuring economical and responsible treatment for those who seek mental health services today. We view the government's PSRO system with great hope and believe that if properly developed PSRO will be a mechanism for determining more effective and appropriate treatment procedures in an area of health service where many questions remain unanswered. Psychologists do not believe that a great deal can be accomplished for the future under a peer review system and a mental health delivery system which retards the effectiveness of an open relationship between the professions working in the mental health area. By assuring access to the different disciplines in mental health, thereby imposing on them the responsibility of working together to find better ways of treating emotional and mental disorders, through PSRO, the Congress will have established the groundwork for rapid future progress in mental health. By failing to adequately recognize the interdisciplinary nature of mental health service, the Congress will have not so much damaged the profession of psychology as it will have damaged the opportunities for better service to the public in the future.

Mr. Rostenkowski. We now provide time for interchange. If there is any comment any panelist would like to make on another panelist's testimony, we would like to do that now. Would anybody like to make a comment in this regard?

Dr. Johnson?

Dr. Johnson. Mr. Chairman, your committee has heard a great deal today about the incorporation of mental health benefits under national health insurance related to a variety of delivery service settings, related to a number of providers and not a great deal of discussion about the welfare of the patient.

I would like to comment regarding that.

It isn't terribly important to me since I am a pragmatist about many of these things, in what type of setting an individual receives treatment or by what individual he receives such treatment so long as the setting is qualified and the provider is reasonably well qualified and these services can be monitored by objective, competent evaluators who will exercise either peer review or some other type of review mechanisms.

Now, I would not take up the committee's time by debating whether or not psychotherapy is a scientific methodology any more than I would whether salesmanship is a scientific methodology.

I would, however, certainly hate to debate the fact that salesmanship is not effective and the output indicators from the utilization of what we call psychotherapy would indicate its effectiveness as well.

I agree with Dr. Taylor that decentralization of the delivery of services to our patients is a excellent way not only in reducing costs, but in many times of providing more active services.

I would question, however, the economics of this unless we are talking about middle-class individuals.

Certainly, those individuals who are chronically ill who may be unemployed and unemployable are a little bit more expensive to maintain in the community if one looks at the whole system than it is to maintain him in a hospital. I do not mean to imply that I think the hospital is the best place for him.

I would simply like to point out that welfare costs are just as high as medical therapeutic costs.

I also would be troubled about an overemphasis on an organized system of delivery as the outstanding approach. It is unfortunately true that services usually follow the dollar. If the dollars are funneled emphatically into one mode of delivery, I think one runs the risk of developing a captive audience who may have no recourse in changing his source of services.

Now, our patients may be ill, but they are not stupid and the marketplace will determine many times where he is going to get the best services or where he feels he is going to get the best services. And he certainly deserves an opportunity to have a free choice among a variety of services.

Thank you.

Mr. ROSTENKOWSKI. Anybody else?

Mr. CHASE. I would, Mr. Chairman.

Mr. ROSTENKOWSKI. Mr. Chase.

Mr. CHASE. I neglected in my testimony to speak to the National Association's position with respect to children and I would say that we concur with Dr. Clotworthy's position on that that children's services evidently require a different kind or kinds of coverage, different kinds of availability of treatment than do adults, and our position specifically calls for unlimited inpatient availability for children.

Mr. ROSTENKOWSKI. Dr. Taylor?

Dr. TAYLOR. I would just like to comment that organized systems of care need not be restricted to the public sector. Organized systems of care can easily be done in the private sector as well as in a mixed form. I do support them because I think they give the greatest guarantee of continuity of service. They also afford more alternatives to the consumer.

He can choose what he needs and is not locked into one service provider who he would use simply because he went through the door of that individual practitioner's office

So, I think there is a strong argument for organized systems of care, but it does not necesarily have to be in the public sector.

Dr. KELLY. Mr. Chairman, I would like to state a strong difference with Dr. Taylor about the general philosophy of psychiatric and mental health care. His position that psychiatric problems are largely problems in living, which have no relationship to difficulties or pathology in the individual, is one that seems to me to take one end of the spectrum of the kind of patients that get into mental health treatment or need to, and overlook the fact that many people have internally developed positions, attitudes, stances, which have little to do with problems between them and other people, and which are not touched by people of mostly good will and a little training in dealing with troubled people, without substantial experience and knowledge of the kind of difficulties, largely developmental difficulties, which are causing people to need mental health treatment.

Also, I would like to state some difference from the position of Dr. Taylor and the National Association of Mental Health that treatment in organized settings is the most effective and most efficient method of treatment.

I believe that there should be a variety of approaches and a variety of opportunities to a patient for types of treatment. I believe these are available in the private sector at this time.

Community mental health centers, I think, have an important position in the delivery of mental health services in this country at this time. To say that they are more effective or more efficient or less expensive I don't believe is true.

I think that they are serving a portion of the population which Dr. Taylor referred to and which I think which needs service. There is still further development of the program of community mental health centers, developments still to come.

So, I am not opposing community mental health centers except in the sense that they should be advocated as superior to other modes of delivery of services. I believe they should not be given a preferential position over other methods of delivery of services.

Mr. ROSTENKOWSKI. Yes, Dr. Dorken.

Dr. DORKEN. Mr. Chairman, I would just like to add a few comments relating to utilization data and experience. Typically when we think of mental health services, we refer to those of the community mental health centers or hospital programs, and those of private practitioners. I think it is of interest to look at the figures produced by the Social and Rehabilitation Services of the Department of Health, Education, and Welfare which show that from the decade of the mid-60s to the present time that there has been a substantial increase in the number of cases under rehabilitation with mental disorder.

It is currently just over 30 precent of all cases under rehabilitation, the single largest disability category.

Of further interest is that the cost of rehabilitation for me mental disorder is less than the cost of some other disabilities handled by these Federal-State programs.

Further, in the majority of cases, there is an average income, gain, subsequent to rehabilitation, so we convert people who were formerly unemployed or marginally employed into productive citizens and taxpayers.

It has been estimated from the increased income that the cost of the service is paid off by the taxes in approximately a year and three-quarters.

So, that is a very clear demonstration of cost effectiveness in these services.

You have heard mentioned this morning of the Kennecott Copper Study. The workers able to use community resources, other organized facilities or private practitioners by their own choice, showed not only reduction in absenteeism, but also a reduction in other health service costs.

A similar study has been reported by Ehlander and Campbell in Oldsmobile's Lansing, Michigan, plant, and it shows a substantial decrease in sick hours and benefits paid were also less.

Collective wages lost decreased 52 percent in comparison to the control group where it continued to grow.

So, these are the kinds of data that suggest that mental health services available under consumer choice are not only cost-effective relative to other health services, but enhance the productivity and care of individuals.

Thank you.

Mr. Rostenkowski. Thank you, Mr. Dorken.

Mr. Chase?

Mr. Chase. Mr. Chairman, there have been some statements made that the—about community mental health centers which prompt me to speak to them.

One was the allusion to the community mental health system as a "public" system. It is a mixed system. It is partly public, partly private. Many, comprehensive of these centers, reason a combination of public and private funding and indeed have their focus at private not-for-profit hospitals.

Now, the statement was made that the community mental health centers were designed to service one segment of the population. But that is not true. My impression is that they are there to serve any member of the public. It is not a poor man's system. It has the potential of being the system of choice.

We also have been speaking, I think, rather loosely about community mental health centers and organized settings as though they were the same thing. They are not.

In the common parlance, the community mental health center is construed to mean an organization which conforms to the requirements of the Federal Community Mental Health Centers Act, and whereas the organized setting is a broader concept which might well include community health centers, group practices, HMOs, outpatient facilities of hospitals, similar organizations to that and indeed a hospital would be construed as an organized setting.

The laws before the Congress, promises before the Congress vary in the respect. H.R. 21 uses loose language with respect to organized settings and indicates a spectrum of organizations such as I just outlined as potential preferential funding mechanisms.

The promise introduced into the House by Mr. Waggonner uses the words, "Qualified Community Mental Health Centers." That is not defined, but one might assume that the proponents had in mind Federal model community mental health centers.

In my estimate maybe it is better when we are thinking of preferential funding to think along the lines of the organized mental health setting and make an effort to define what that means for insurance purposes.

Dr. Taylor. Mr. Chairman, I would just like to add onto Mr. Chase's statement and share with you an example of how an organized system can be developed that merges public and private contributions.

In the community mental health center in Marin County, Calif., we developed a system which was basically a mixed system. The public sector provided the framework for essentially coordinating a large number of private services. We did it this way: We had 9 program divisions, each of which had a small public sector staff. In addition, each of these program divisions had a checking account, if you will. They had freestanding contract funds which were available to purchase services from the private sector in the interests of the clients.

When someone would come into one of our units and we didn't have a specialized service, say, behavior therapy, we would write out a voucher and send that person to the Behavior Therapy Institute with which we had contracted to do business, and could pay for services in the private sector for that service, strictly on a free-for-service basis.

This, then, is an example of a merger of the public and private sectors into an organized system of care.

We feel it has considerable potential.

Mr. Rostenkowski. Yes.

Dr. Clotworthy. Mr. Chairman, I would like to speak regarding this issue of the economy of an organized setting versus that of a setting like private practice. I work in an organized setting a good portion of the week. We work as a team in a residential treatment center and the team is necessary because various disciplines are appropriate to the various tasks which need to be done. So that there are psychiatrists, psychologists, social workers, special education teachers, paraprofessionals, and so forth.

This team though, in working as a team, must spend a considerable portion of their week communicating with one another. In fact, the therapists there are able to spend actually only about half of their time actually in the treatment of the children. There is therefore a certain inefficiency in working as a team in that so much time must be spent in communicating with one another.

There are certain economies in that certain team members do not get as high salaries as other team members, but that economy is lost to a considerable degree by virtue of all the administrative and communicative time that is spent. I am able to contrast my own work as a single private practitioner where I do not have to spend any time communicating with myself. All the functions that a child psychiatrist performs in the private practice are done by one person. All of my time is spent actually getting the job done and treating the patient, and his family.

Thank you.

Mr. Rostenkowski. Dr. Chodoff?

Dr. Chodoff. It would seem to me that when this committee proceeds to write whatever act it is going to, that a guiding principle ought to be a pluralism of mental health delivery systems. It is not an either/or thing. Community mental health centers fill a definite need. Now, that sounds as if I am damning with faint praise, but they serve a useful function and are necessary.

However, many of them in this country range in efficiency from A to terrible. There are all kinds of turnovers in their leadership and personnel, but I think that is inevitable. Although Mr. Chase says they are available to all segments of the population, in fact, they do serve mostly poor and disadvantaged people.

Accordingly, health services tend to get confused or mixed up with other kinds of social services and the community mental health centers tend to depart from health care, unless you define it so broadly that it becomes relatively meaningless. Political issues enter very frequently. Bureaucracies enter, there is a swelling of patient care costs and overhead costs. I think there are some pretty good figures which indicate that an hour session of care for a patient in community mental health care is not less expensive than that in the office of a private practicing psychiatrist.

This may be surprising, but it is in fact true.

Furthermore, and finally, I think it is important—since no one has the exact answer of how to provide this care in this country, we need some competition, we need to encourage various systems of mental health care delivery to give people a choice and allow the better ones to emerge in this competition.

Mr. Rostenkowski. Dr. Kelly, what is the usual charge for a 30 minute or hour service in this area?

Dr. Kelly. The average charge presently is $40 per hour, 50 minutes.

Mr. Rostenkowski. It is a fact though that there are more psychiatrists in this area than any other area of the country?

Dr. Kelly. Certainly, it is one of the most highly populated by psychiatrists.

Mr. Rostenkowski. I know there is a need for it, I just wonder whether there were enough.

[Laughter.]

Dr. Chodoff. That figure is somewhat—generally, it is wrongly stated. The District of Columbia is, in fact, a State, but it is compared to cities. If you compare the District of Columbia to New York City, I think you would find that there is more psychiatrists per capita there than here.

Mr. Rostenkowski. In New York, N.Y.?

Dr. Chodoff. Yes, compared to New York, N.Y., there are more there. So, it is not an accurate statement to compare the District of Columbia with States. You should compare it with cities.

Dr. Kelly. Many psychiatrists here are in connection with Federal agencies and that sort of thing, NIMH, St. Elizabeth's Hospital, and that would swell the numbers in our society here by a good many.

Mr. Rostenkowski. If competition is the rule and there are as many psychiatrists as there are in the District which we consider a State, then in the competitive market the price for service per hour should be lower than it would be in another section of the country, wouldn't it? Or it should be?

Dr. Kelly. Yes, you would think so.

Mr. Chase. That is not true, Mr. Chairman, as you, perhaps, know. There is no correlation between the number of psychiatrists per hundred thousand population and the rates they charge. In fact, in some of the rural areas where there are far less psychiatrists, the rates are lower.

Mr. Rostenkowski. If due to cost constraints comprehensive mental health benefits had to be phased in, how would you suggest we do it. I solicit that answer from anybody on the panel or all of you.

Dr. Dorken. Mr. Chairman, I think there is an axiom here that should be considered closely. That is that the program follows the dollar and if we continue to provide the same kinds of fiscal incentives that most group health insurance plans have to date, we will continue to emphasize inpatient services which are not necessarily the most effective, as you have heard from other witnesses today. And, certainly, far more costly.

In the CHAMPUS program for example in fiscal 1974, 58 percent of the expenditure went for per diem hospital costs and other inpatient professional visits drove the cost for inpatient services collectively to 70 percent of the total program expense, but merely served a minority of the population.

Similarly in the Short-Doyle program for a minority of the people being served, a majority of the money was spent on inpatient services with no noticeable gain in effectiveness.

There are some studies that have tried to reverse this. Pacific Southwest which is an HMO in southern California decided to place the deductibles on hospitalization and provide first dollar coverage for ambulatory care, and what happened? The experience is that the number of claims increased very substantially, but, of course, they were of smaller amount and the net cost at the end of the year was far less. The consumers were much happier. Dr. Mendall of the University of Southern California attempted an outpatient program with a selected group of welfare recipients and out of the 6,000, only one required hospitalization in the year and the average cost of the service was less than 50 cents a month.

In California's medical program the administration attempted to introduce what they thought were cost controls such as prior authorization for more than two visits a month. They showed that doctor visits declined and 3 months later when they introduced co-pay, the doctor visits declined again, but what Roamer's study shows in medical care of June 1975, is that concurrently it drove hospitalization up so that the net effect of those cost controls was to increase the costs to the State of California $1.25 million.

What I would like to emphasize again is that we should emphasize an ambulatory care benefit package in terms of dealing with the problem of mental disorder and that that will be the most effective and the least expensive in the long run.

Thank you.

Dr. Kiesler. A different point on phasing-in. Presumably, one would phase-in because of lack of money available. But I would hope that whatever money is available that there would be a strong evaluation component to each phase. There are various ways of doing that so that some of the questions that you have raised today could be answered as we progressed along a sequence in phasing. Some of this information is simply not available now because the world is not constructed to answer impeccable questions when patients come in on a self-selection basis when they feel like it. I would hope whatever money is available at any given step in the sequence that there would be an evaluation component to the phase itself.

Dr. Taylor. It seems to me you have two general strategies to consider in "phasing-in" mental health services.

One would be to provide coverage for one service at a time. Perhaps you start with emergency services and later add outpatient services and so on.

The other option, one more appealing to me, is to have a comprehensive package, but have it scaled down as to the quantity of benefits in each area. I say that because our past history in mental health care is that when you can only offer one service and nothing else, then generally the whole thing falls apart. It is not very successful. A lot of the people who have the most severe problems need a package of services. Unless you have the package, the one service you provide really doesn't work very well and it gets overused. I think I would opt for that option in phasing-in rather than the first.

Mr. CHASE. I would agree with Dr. Taylor that that is the preferable way to do it. I would further urge that if it is necessary to phase it in that it be according to a pre-determined rate of broadening, that there be a distinct program in the original legislation that says, "Here is the first package, and here is the second package to be effective in 1970-something." And; then the third package in 1980-something, so we don't find ourselves out in left field with the sun in our eyes, and somebody saying, "It cost us more than we anticipated."

Mr. Chairman, I have to confess to a bad job of planning my day and I have a family commitment at home which I must leave for, if you excuse me.

Mr. ROSTENKOWSKI. Thank you, Mr. Chase.

Dr. CLOTWORTHY. In regard to the question of phasing-in, I feel that the country cannot afford to have a phasing-in process regarding services for children. The services provided earlier in life are of a preventive nature even if they are in the form of actual treatment. They are preventing problems for the remainder of the person's days.

I feel strongly that children need the whole range of services from the very beginning.

Mr. ROSTENKOWSKI. Dr. Johnson?

Dr. JOHNSON. Traditionally, the largest number of tax dollars on the State level have been spent for mental health services compared to any other health services. I think it would be quite discriminating if one phased-in mental health services for a substantial and measurable number of people who are suffering from these types of illnesses and diseases and put them in double jeopardy of taxation. If they are being taxed through the Federal system for health services and again at the State level for health services and they are only able to receive those; that the State provides through their own tax dollars, then this kind of discrimination would be in a sense disenfranchising a large number of people from access to the kinds of care they need.

Mr. ROSTENKOWSKI. Mr. Duncan will inquire.

Mr. DUNCAN. Thank you, Mr. Chairman.

I would also like to thank the panel. I think it has been one of the most interesting ones we have had to date in the hearings on national health insurance.

If outpatient psychiatric care is provided under national health insurance from Federal funds, what mechanism, if any, for effective monitoring and control over cost and quality of care should be provided?

Dr. CHODOFF. A program of that magnitude requires, of course, a very large operation. I believe, however, that the model that I suggested briefly and without any detail would serve to effect monitoring of the practices which were permitted under the legislation. That is, I am clearly opting for professional peer review, and monitoring of the services. Can we do it?

I think that is a question that has to be answered.

I believe it would be far preferable to have the attempt made in the first place for professional monitoring of the services which that profession renders.

I hope that the committee and people like yourself would watch very closely developments in this area.

Mr. Duncan. Would you recommend something close to the peer review such as the PSRO's?

Dr. Chodoff. Yes, well, the PSRO's would function both roughly as I would describe the activity of the Washington Psychiatry Society Peer Review Committee, that is to take part in three activities, establish standards, monitor claims, and to educate its members which might include the need for re-education and possibly even taking action against a particular member whose activities verged on the unethical or incompetent.

The members of the profession know where the bodies are buried better than anyone else and they might look into practices that would not be visible to non-members.

Mr. Duncan. Could one or more of the panel give me an idea of the costs that we are talking about if the program that you advocate is made a part of the national health insurance program?

Dr. Johnson. Yes, I will have Dr. Reed respond to that.

Mr. Duncan. All right, fine.

Dr. Reed. Well, I think that the best indication of cost is that afforded under the Blue Cross and Blue Shield plan for Federal employees which does provide practically complete service and the same, practically the same coverage, for mental conditions as for other conditions.

Under that plan, in 1974 now, the total cost for all mental health benefits was $13.74 per person which was 7.3 percent of the cost of all benefits for all conditions. Now, there are many plans and insurance programs in which you find a lower cost, but part of that lower cost is because of the provision of reduced benefits.

It is interesting that under the Blue Cross-Blue Shield program about 60 percent of the total cost for mental care is going for inpatient care including the hospital care and physicians' services in the hospital.

Only about 40 percent is going for care outside the hospital.

Mr. Duncan. In other words, you would think of maybe 5 to 7 percent of the total medical cost might be a fair estimate of the cost of the program that you advocate?

Dr. Reed. I am not sure that I heard you clearly, but——

Mr. Duncan. You indicated that the Blue Cross experience was about 7 percent?

Dr. Reed. About 7 percent, yes.

Mr. Duncan. Of the total medical cost?

Dr. Reed. Yes.

Mr. Duncan. Do you think that would be a fair estimate?

Dr. Reed. It has been on that level now for the past 3 years. Formerly, it increased steadily ever since the program was instituted and that was in 1960. Part of that increase in cost was due to enlarged benefits for mental care.

Mr. Duncan. You indicate—and I will direct this to Dr. Kelly now—you indicate that great cause of cost has been because of inpatient care and Dr. Kelly, I think, you suggested there be no specific limit on the inpatient care for mental illness. Don't you think that outpatient care should be encouraged over inpatient care?

Dr. Kelly. Yes, that would be my emphasis. I think that care should be appropriate, and if it is done this way, with outpatient care and partial hospitalization, available and used correctly, the inpatient's more expensive care will be reduced in useage. That is the best approach to this, I think.

Mr. Duncan. I have noticed in my State that many of the practicing phychiatrists are graduates of foreign medical colleges. Is that a trend or how is that? Or perhaps I should say the majority in our mental institutions are foreign graduates.

Dr. Johnson. It is not so much a trend as a necessity. The kinds of salaries that State systems offer do not attract other than foreign medical graduates at the present time and since many States provide provisional limited licensure for services in State operated facilities they accumulate a large proportion of foreign medical graduates because of the inability of some of them to achieve licensure on a State level otherwise. Even though they may pass their ECFMGs they, many times, will not go on to attempt the State licensing board examinations. I think this probably is another reason for attempting to provide coverage for ambulatory services of all sorts, including partial hospitalization so that we can gradually diminish utilization of these large centralized facilities where the care, many times, may not be of the quality that can be received in the community.

Mr. Duncan. Would you think that there is a great number of people in the mental institutions today that could be cared for on the outside?

Dr. Johnson. Yes, I think there are. This is something that was demonstrated. The level of care varies from State to State when large institutions are gradually phased out so that in the overlap between the phasing down of large centralized institutions and the expansion of access to care in the community occurs it will be more expensive because there will be a duplication of expenditures during this period. However, down the pike I think it would turn out to be far more economical.

Mr. Duncan. Would any other member care to respond?

Dr. Kelly?

Dr. Kelly. I would like to make a statement in the nature of a warning about reducing the number of patients in large institutions. I think this should be reduced in a thought out, sensible way rather than by a blanket decision to close down the mental hospitals. If this is done, large numbers of seriously disordered people are put out into the communities without care, as Dr. Johnson said, without facilities for ongoing care and it is just a mess. You hear stories about the situation in Long Island where the New York State hospitals discharged many patients and they are just vagrants and a peculiar, odd kind of bums in the civilian communities where they live.

Mr. Duncan. Wasn't there a court decision recently that said if hospitals could not treat the patients there they must release them?

Dr. Johnson, you are kind of shaking your head. I seem to remember about such a case.

Dr. Johnson. This was a decision which was a very narrow one, Mr. Duncan, relating to people who had been civilly committed, who were not dangerous to themselves or others, and who were not receiving treatment, that they should be discharged provided they could live safely and in safety alone or with the care of relatives or friends.

Mr. Duncan. That would probably result in a number of people being released, that would perhaps need help outside.

Dr. Johnson. I think so, yes. It was oriented to assuring the fact that adequate treatment would take place within the hospital if hospitalization was necessary.

I also spoke to the doctrine of least restraint and certainly this is a good philosophy.

Mr. Duncan. It will present some problems to State operated mental institutions.

Dr. Johnson. It will present a problem to those State institutions which are not now able or willing to provide the kind of adequate treatment that has been spelled out in many court decisions.

Mr. Duncan. How about other panels? Do you think there are a great number of people in the institutions that could be treated outside instead of in? I would like a personal opinion if each of you could.

Dr. Chodoff. I can't do that.

Mr. Duncan. Can any others do that?

Dr. Taylor. Just 2 weeks ago, the commissioner of mental health in Texas had a task force go to Terrill State Hospital to review the cases in that hospital. They found approximately 40 percent of them could be on the outside if there was a place to go. I don't think Terrill is unlike a lot of State hospitals in this country. There is another side to that, however. Over the past 10 years, there has been a significant reduction in State hospital population in this country. The problem is that a lot of those people have been turned out of the State hospitals and have gone into board and care homes where no treatment is provided and that is not a very good alternative.

I think the issue you are focusing on is a very,very important one. As you review the history of mental health care you discover all sorts of ingenious ways that our society has had of ducking this issue, whether it is community mental health centers or State hospitals or private practitioners. The seriously mentally ill in this country have never been cared for and I would hope that in drafting any form of coverage, your committee uses considerable ingenuity in trying to assure that this group of people really do get the services they need, much of which could go on outside institutions.

Mr. Duncan. Having been in local government, it always appeared to me we just sort of shoved out of sight anyone not in the mainstream.

Dr. Chodoff. This is one of the most pertinent and difficult, thorny questions that you will have to deal with. I should say for one thing, a lot of people in State hospitals are there because there is no other place for them to go. The psychiatrists don't want them there but where else will they go? The precipitate deinstitutionalization now taking place is disgraceful. Dumping ill-prepared people on the communities, shifting the burden from the State hospital to a community, is a service to no one. I think this is partly due to the fact that as everyone here knows a lot of the people don't need to be in hospitals. Hopefully, if more measures are implemented to pretreat, institutionalization won't be necessary.

However, I want to cite a cautionary note. Some people need to be in hospitals and are being pushed out before they are ready by virtue of all of the public clamor that we are having overdeinstitutionalization. Properly constructed and administered small hospitals serve a very definite need and will continue to do so as long as some patients need to be in them.

Dr. CLOTWORTHY. I would like to say a word regarding children and adolescents, that the choice is not between hospitals and outpatient services. In the spectrum of services there are several other kinds of settings that are not familiar generally to the lay public.

Residential treatment differs from a hospital in that it does not have laboratories, X-rays, or as much nursing coverage. It costs about half as much as hospitalization.

Blue Cross has not covered residential treatment except in rare instances around the country. So, that many children and adolescents have been channeled into the more expensive hospital treatment because that is where the coverage was available. Less expensive than residential treatment are therapeutic group homes. A family-type of living in a house with specially trained surrogate parents in charge of the house.

There are therapeutic schools still less structured.

Mr. DUNCAN. Dr. Clotworthy, my time has been up for some time. I apologize for going over. Thank you, Mr. Chairman.

Dr. DORKEN. Mr. Duncan?

Mr. ROSTENKOWSKI. Mr. Burleson?

Mr. BURLESON. Mr. Chairman, thank you, I think this panel has been explored very well.

Following your innuendo, however, about the number of those in the behavioral sciences here in Washington and perhaps there is greater need for it, I would just like to observe, I wonder what the reaction of this panel would have been if they had been present during the recent hearings on tax reform.

[Laughter.]

Mr. BURLESON. I think it is probably just as well we didn't have them.

Thank you, Mr. Chairman.

Dr. JOHNSON. Mr. Chairman, may I respond to one of Mr. Duncan's questions? He mentioned earlier the question of monitoring of ambulatory psychiatric services.

With regard to deinstitutionalization procedures and the provision of care in the community, I feel it is just as important to monitor the kinds of facilities that are providing this care, whether they be boarding homes, residential treatment facilities, day treatment centers, outpatient clinics or whatever, it becomes an obligation of the State to develop some means of monitoring these types of facilities in order to assure that they are offering high quality care as well.

And also, although not all States do so, many of them have instituted licensing procedures which does provide this kind of monitoring for adequate community based services.

Mr. DORKEN. Mr. Chairman?

Mr. ROSTENKOWSKI. Yes.

Dr. DORKEN. I would like to go back to two questions raised by Mr. Duncan, one relating to the cost of mental health care and how to control that cost.

You heard Dr. Reed say that in the Federal employee Blue Cross-Blue Shield program that the proportion of costs for mental disorder was 7.3 percent and I would like to underscore that if that 7.3 percent were not expended, it would not be a cost foregone. Rather, I would claim that the fact that there was that kind of adequate mental health coverage truly reduced the total cost of the program and that kind of viewpoint is backed up not only by studies at Kaiser in California, but through the Group Health Association in this city here and the health insurance plan of Greater New York and other experiences reported. If we do not provide the mental benefits we do not save funds, we actually increase the cost of health care.

Now, to the other question. In terms of control, I think too often with limited health coverage, the decisions that the consumer makes in terms of needs for health care are really not health decisions, but economic decisions. I would hope that with national health insurance, it might be sufficiently comprehensive that the decisions could be made on the basis of need for health services. In doing this, I think it is time we placed the controls upon the provider rather than upon the consumer. I think this can be done through organized peer review where not only actual utilization and procedures are again brought under control, but where better standards of practice are developed. There are other possibilities as well and these involve such things as continuing education for relicensure which is a fact of life in some States already and there is beyond that the possibility currently under debate in several professions of the possibility of specialty certification on top of the generic licensure to insure and improve quality of performance by the provider to the consumer.

Thank you.

Mr. Rostenkowski. Yes, Dr. Reed.

Dr. Reed. I think that as a statisticianery economist, I better qualify my reply to Mr. Duncan's question a bit.

First of all, the Federal employee population is not fully representative of the total population of the United States and you are thinking of what would be the cost for the whole population.

The Federal employee population probably uses more service, more psychiatric and mental health services than the rest of the population in that it is probably a somewhat higher income class and better educated and have a more white collar composition.

So, that is one factor that would tend to make the cost for the whole population less, at least in the first few years of the program.

On the other hand, the population does not include people who have never been part of a working population or the dependents of such a population, and it does not include, would not include the cost of hospital care in State hospitals for people who have, in effect, never been part of any insured population.

So, that is a factor which would tend to increase the cost and where you come out on balance, I am not quite sure.

Mr. Rostenkowski. Dr. Chodoff, would you tell us what the average length of treatment for, and frequency of, visits for psychoanalysis and whether you would recommend that it be covered under national health insurance?

Dr. Chodoff. I am afraid I can only give you impressions in that area, Mr. Rostenkowski.

I would say that the average length of treatment for procedures called psychoanalysis, which tend to be somewhat differently defined by different people who practice it, would be 2 to 3 years. The frequency of visits per week to my mind would be three to five times a week.

Mr. ROSTENKOWSKI. Would you recommend that it be covered by national health insurance?

Dr. CHODOFF. I believe that the experience here in Washington has demonstrated that it does not provide an impossible burden for the financial setting. As far as need is concerned, it is a very intensive method of treatment and it is applicable only to a relatively small proportion of individuals, and this is even independent of financial considerations. There are certain diagnostic, personality, and other criteria which must be satisfied before legitimately a person should be treated with this method.

In those people for whom it is indicated, I believe it is the treatment of choice and if they don't get that particular variety of treatment then they are not getting what they need.

Mr. ROSTENKOWSKI. Would anyone else care to comment?

Dr. Taylor?

Dr. TAYLOR. I would like to add a perspective to Dr. Chodoff's reply. As far as I know there is no evidence to suggest that that psychoanalysis as a form of treatment intervention is superior to other kinds of intervention that are considerably less costly. There is just not data to document that position.

Mr. ROSTENKOWSKI. Dr. Clotworthy, the practice of prescribing barbiturates for children diagnosed as hyperactive seems to be spreading at an alarming rate. Does the American Academy of Child Psychiatry have any position on this practice?

Dr. CLOTWORTHY. On the prescribing of—I didn't get the word.

Mr. ROSTENKOWSKI. Prescribing of barbiturates.

Dr. CLOTWORTHY. I believe you have reference to amphetamine-type drug prescriptions which are stimulants as opposed to sedatives as the barbiturates are.

I don't think the academy has an official position, but I am able. I think, I can easily say what the broad consensus of members of the academy would be regarding this.

The use of these drugs can have a highly beneficial effect in a majority of hyperkinetic, hyperactive children. Sometimes it is dramatic, the change that can take place overnight with tremendous consequences for benefits to the child the rest of his life, and for his family who have to live with the child.

Now, the use of this drug can be abused if it is prescribed without a careful study of the child and his family. The drug should not be used alone without consideration of services in the form of counseling to the parents, psychotherapy to the child, need for special education for the child in special school settings; I would say that we would not find anything alarming about it at all except as how it is abused where there are not careful studies made of each child.

Now, there are some side effects of the drug. In a few children, it disturbs sleep at night, but with careful managing of the timing of the drug that can be generally taken care of.

There are questions about—there has been some controversy about whether the ultimate physical growth of the child may somewhat be diminished by long-term use of the drug, but that is something that has not been clearly proven and to my way of thinking, if the child would be slightly, ever so slightly shorter as a result of use of the drug, that that is not necessarily a contraindication considering all of the positive benefits that the drug offers.

Mr. ROSTENKOWSKI. Is it true that there was a study made and a conclusion drawn that food additives create hyperactivity in children? Would anyone like to comment on that?

Dr. Clotworthy.

Dr. CLOTWORTHY. This is a pioneering effort on the part of one pediatrician who is a specialist in allergies. He is highly enthusiastic about his own personal experience within it, apparently, a good many of his patients are as well.

He has gotten a good bit of publicity which comes really in advance of any scientific studies to bear this out.

So that it has a certain, you know, it sounds good if it can be proven to be true, but it is too early to say.

Mr. ROSTENKOWSKI. The gentleman from the Psychological Association, in your discussion of coverage of mental health benefits under existing health insurance plans, you note that some plans offer extensive benefits and employ few controls.

Two questions; how much can benefits be limited and still be effective?

2. What are the controls that we should supply?

Dr. KIESLER. If you don't mind, I would like Dr. Dorken to answer that. This is his area of research.

Mr. ROSTENKOWSKI. Dr. Dorken?

Dr. DORKEN. The utilization patterns as we have observed both reported in community mental health programs and in a number of group health programs such as Kaiser, suggest that the median number of visits per year by a user on an outpatient basis is somewhere between five and six visits. This suggests to us then that the cost is minimal for such service and that it would be better provided at a first dollar coverage basis, open entry, to encourage early intervention and if cost controls are necessary to contain utilization that they come subsequent to these visits. Concurrently, if it is expected that the number of visits might exceed a level of six or so, attending therapist file a treatment plan in which objectives are stated and outcome anticipated.

Doing that is a way of leading to effective program evaluation which Dr. Kiesler mentioned beforehand.

For example, at the Peninsula Hospital in Burlingame, Calif., the county has contracted with private providers to deliver mental health services on a capitation basis. They have controlled the utilization in this manner and it has worked very effectively.

If extensive visits are needed, say beyond 15 in a year, then the therapist must go before his peers and acquire prior authorization and again that becomes possible, but under a system of controls and judgments.

Does that help to answer the question?

Mr. ROSTENKOWSKI. Thank you.

Are there any further comments that anyone would like to make?

I want to thank you all for joining with us this morning in helping us make this record. I am sure when the committee does sit down to write national health insurance that your contributions will certainly be of great help.

On behalf of all the members of the Subcommittee on Health, we sincerely appreciate your taking your time and joining us this morning.

This concludes the hearings for today.

Thank you very much.

[Whereupon, at 11:21 a.m., the hearing was adjourned, to reconvene at 10 a.m. Monday, November 17, 1975.]

NATIONAL HEALTH INSURANCE

MONDAY, NOVEMBER 17, 1975

U.S. House of Representatives,
Subcommittee on Health,
Committee on Ways and Means,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to notice, in the committee hearing room, Longworth House Office Building, Hon. Dan Rostenkowski (chairman of the subcommittee) presiding.

Mr. Rostenkowski. Good morning, gentlemen. Welcome to the committee.

I would like to explain the format. We ask that each of you make your statement first. At the conclusion of all the statements of the panelists we encourage an interchange with regard to each other's statements. After 15 or 20 minutes, the members of the subcommittee will ask questions.

If, Mr. Santore, you will begin your testimony, the committee is now ready to receive it.

PANEL ON MENTAL HEALTH CONSISTING OF ANTHONY SANTORE, CHAIRMAN, NATIONAL COUNCIL OF COMMUNITY MENTAL HEALTH CENTERS, ACCOMPANIED BY JONAS V. MORRIS, GOVERNMENTAL AFFAIRS REPRESENTATIVE; MIKE GORMAN, DIRECTOR, PUBLIC POLICY OFFICE, NATIONAL COUNCIL ON ALCOHOLISM; ROBERT M. BEAUREGARD, LEGISLATIVE CONSULTANT, ALCOHOL AND DRUG PROBLEMS ASSOCIATION OF NORTH AMERICA; AND WRIGHT WILLIAMSON, EXECUTIVE DIRECTOR, NATIONAL FEDERATION OF SOCIETIES FOR CLINICAL SOCIAL WORK

Mr. Morris. Mr. Santore and I are together representing the National Council of Community Mental Health Centers and, if I may make a few comments, Mr. Santore will present the testimony.

I am Jonas Morris, governmental affairs representative for the council, and Mr. Santore is chairman of the organization. In earlier testimony that has been submitted for the record in your hearings last spring we addressed ourselves to the elements that we thought should be in National Health Insurance for mental health coverage. Today we want to talk about some other aspects of the program, namely, systems of care and how we think the elements can be interrelated.

We do have a prepared statement that we would like to have included in the record.

Mr. Rostenkowski. Your statement in its entirety will be included in the record, Mr. Morris.

Mr. SANTORE. Mr. Chairman, this is a statement presented on behalf of the National Council of Community Mental Health Centers, representing 328 community mental health centers, and 128 agencies which are developing CMHC programs or which have a direct interest in community mental health.

The statement outlines the Federal CMHC program, its goals and achievements and provides summaries of cost data showing that CMHCs are generally less expensive than general and psychiatric hospitals and most private practitioners and data on the effectiveness of CMHC services.

The statement also describes the system of mental health care which is established by a federally funded community mental health center. Each CMHC is designed to serve a specified geographic area and provide a full range of comprehensive services to all residents in the area. These services include prevention and early intervention programs, health education, and a complete range of treatment modalities which emphasize provision of care through outpatient services, day treatment, partial hospitalization, and other alternatives to expensive inpatient care. When inpatient services are provided, stays are kept to a minimum.

CMHC's are required to ensure that all services are coordinated with the provision of other mental health services in the community, and with other health and social services. This means that centers review all existing services in the area, pull these together into a coordinated program, make provision for filling gaps in services and attempt to eliminate unnecessary duplication.

CMHC's have developed outreach programs to ensure that all individuals in the area are aware of services and encouraged to seek treatment. Accessibility of services, in terms of both maximum use of all available manpower, including all mental health professionals, paraprofessional personnel, and specially trained mental health workers to hold down costs, and increase availability of services.

Congress and the administration are both concerned now with various issues which have been emphasized by CMHC's for many years—preventive care and health education, discouragement of inappropriate hospital stays, accessibility, and coordination of services to improve continuity of care and elimination of duplication.

To date, several steps have been taken to improve the health delivery system prior to enactment of National Health Insurance: the passage of the Health Planning and Resources Development Act (P.L. 93–603) and the Community Mental Health Centers Amendments of 1975 (Title III, P.L. 94–63) as well as laws supporting health maintenance organizations and neighborhood health centers.

In enacting NHI, the committee should build upon these existing initiatives and make various improvements. NCCMHC recommends the passage of an NHI bill which will encourage the development of systems of mental health care by:

Requiring effective and formal linkage between all mental health providers in the area or community, including CMHC's (if established), hospital, private practitioners, specialized treatment programs, and services, et cetera, so as to ensure that every patient has direct access to all covered services through the provider he first contacts.

Replacing the Federal categorical grant with a reimbursement system for funding services provided by CMHC's which meet Federal standards, as spelled out in the current Community Mental Health Centers Act.

Specifically including CMHC's which meet such standards as providers of care under NHI, and including as covered services all CMHC services provided by mental health professionals and, under appropriate supervision, by paraprofessionals and other mental health workers, whether provided in the main center facility or elsewhere.

Instituting a system of peer and utilization review with national guidelines designed to eliminate inappropriate inpatient care for the mentally ill.

Reimbursing outreach and other case-finding activities of mental health providers to facilitate early intervention.

Setting up a system of reimbursement which ensures that mental health care consists of active treatment only.

Setting up a system to ensure that the Federal Government has control over reimbursements for services, to ensure that reimbursements are reasonable, and providing arrangements for prospective reimbursement of provider agencies so as to encourage efficiency.

[The prepared statement follows:]

STATEMENT OF THE NATIONAL COUNCIL OF COMMUNITY MENTAL HEALTH CENTERS

(By Anthony Santore, Executive Director, Northwestern Institute of Psychiatry, and Chairman, National Council of Community Mental Health Centers; and Jonas V. Morris, Governmental Affairs Representative, National Council of Community Mental Health Centers)

INTRODUCTION

This statement is presented on behalf of the National Council of Community Mental Health Centers (NCCMHC) representing 328 community mental health centers, most of which receive federal funding under the Community Mental Health Centers Act, and another 128 agencies which are developing CMHC programs or which have a direct interest in community mental health.

EXPLANATION OF STATEMENT

NCCMHC has previously testified before the Ways and Means Committee concerning the need for coverage of community mental health services under national health insurance. Our most recent testimony was submitted in April 1975 for the record of written statements on NHI, and appears on pages 1142–1152 of the Committee's printed document, "Written Statements Submitted by Interested Individuals and Organizations on National Health Insurance."

This statement does not therefore repeat the previously presented NCCMHC testimony on specifics of coverage of mental health services under NHI, nor does it address the issue of costs of providing such coverage which has been well documented in recent years and which will be discussed by other groups testifying before the committee.

Instead, in this testimony we would like to address some of the broader issues of national health insurance, particularly the impact of such a program upon the health services delivery system and how national health insurance can have some impact on the major problems of the American delivery system such as accessibility, continuity of care, emphasis on preventive services, health education and appropriate treatment (including home health care and outpatient services coverage and elimination of inappropriate institutionalization) as well as cost and quality controls.

FEDERAL CMHC PROGRAM: GOALS AND ACHIEVEMENTS

The community mental health centers program was established by Congress in 1963 to make a wide range of mental health care services readily available to residents of a given geographic area. The goal of the program is to establish a CMHC which meets federal standards in all parts of the country, or roughly 2,000 centers. CMHCs have been the focal point in a national effort to alter dramatically the traditional pattern of mental health services in the country and have had a significant impact on the mental health system—on the organization and delivery of services, as well as an accessibility and accountability of programs to the community they serve.

Since 1963, a total of $1,225 million has been appropriated for the program, and the number of centers initiated with federal funds has increased to 630, about 500 of which are now fully operational and offering services to their community. When all 630 centers are operating, 90 million people in the United States will live in areas served by a comprehensive CMHC.

In 1973, these centers treated approximately 1.25 million persons—25 percent of all mental health care episodes in public and private facilities (excluding private practitioners).

(*a*) *Goals*

The primary goal of CMHCs is the provision of a full range of mental health services within the patient's own community. Services range from prevention to inpatient care, but the accent is on ambulatory care which facilitates an easier adjustment after treatment and permits the individual to remain a functioning, productive member of society while receiving treatment.

While the centers are intended to develop effective community alternatives to long-term institutional care of the mentally ill, they have a number of other responsibilities which make them unique in terms of program foci among mental health programs. These foci, stressed since the beginning of the program and emphasized in new legislation enacted this year by Congress (P.L. 94–63, Title III, the Community Mental Health Centers Amendments of 1975), result in the development of system mental health care services in each community. Unlike most federal programs, CMHCs have responsibilities which go far beyond the delivery of direct health care services to those in need.

First, each CMHC is responsible for serving a specified geographic area, termed a catchment area, and for providing a full range of services to all residents in that area, including preventive services, early intervention and emergency services.

Each center must either develop a full range of mental health services, or ensure that such services are available in the community through other agencies which affiliate and cooperate with the CMHC. These services include various outpatient therapies, emergency services, partial hospitalization, transitional living arrangements and other alternatives to institutional care and after care services as well as 24-hour inpatient services. In addition, specialized and comprehensive programs to serve the needs of population groups with special problems must be established. These include programs for children and the elderly and, if no alternative services are available in the community, programs for alcoholics and drug addicts and abusers.

A vital part of any CMHC program is its consultation and education service—the preventive, early intervention and health education program. Through these programs, centers develop consultation services for various community agencies—schools and other educational institutions, police and correctional agencies, welfare departments, social service agencies, and various health professionals. Consultation from the center enables the staff of these other agencies to better handle problems arising from mental or emotional disturbance, to understand the services of the center and to more appropriately refer individuals in need of treatment to the CMHC. This greatly facilitates early intervention. Through these consultation programs and through various education programs operated by the centers agencies, providers and individuals are better able to understand and recognize mental health problems and to deal with them.

Two other important aspects of the CMHC's role are the accessibility of services and continuity of care for patients under care. CMHC's are charged with ensuring that the full range of required comprehensive services are both available in the community and accessible to all parts of that community in terms of their physical location (ease of travel to the facilities, etc.) and other barriers to service arising from socio-economic factors. Services are to be available to all, regardless of their ability to pay.

Fragmentation and lack of coordination between services is a major problem in the delivery of human services. CMHC's are charged with ensuring that all services required under the Act are provided, either by the center or through agencies which have written affiliation agreements with the center. This ensures continuity of care for patients and prevents individuals from "slipping through the cracks"—an all too common problem when no formal linkage exists between services in a community.

CMHC's are also required by law to ensure that these required mental health services are properly coordinated with other related health and social services in the community.

(*b*) *Achievements*

The CMHC program has been operational now for about 10 years, and a number of studies and much data are available which show the effectiveness of these programs.

First, with regard to provision of alternative community services for individuals who might otherwise have been institutionalized, frequently for many years, the CMHC's have consistently reduced the level of admissions to a state mental hospital from their catchment area at a rate far higher than for other areas with no CMHC.[1] A number of studies have documented this trend, showing nationally that if an individual lives in an area with a fully operating center his chances of being admitted to a state institution are reduced by a third. In certain states, however, the difference is even more dramatic, with the number of persons admitted from CMHC catchment areas dropping, while admissions from other areas of the state increase.

Partly because of the impact of the CMHC's and the availability of improved drugs for treating the mentally ill, the resident population of state mental hospitals continues to decline at an accelerating pace—down from its peak in 1955 of 558,922 to 219,102 in 1973.

Studies also show that intensive community treatment can result in considerable dollar savings over institutional care, in addition to improving quality of care.[2]

The costs of care provided in CMHCs is generally less than other community alternatives. For instance, a comparison of costs in a CMHC with those of a general hospital psychiatric unit and a psychiatric hospital shows the cost in CMHCs to be $1,590 per inpatient episode of care; in general hospitals $1,840 per episode; and in psychiatric hospitals, $2,888 per episode.

CMHC outpatient charges are also low; on average $30.39 per visit compared to charges by private practitioners (based upon charges to CHAMPUS in 1974) of $35 per visit for a psychiatrist; $33 per visit for a psychologist and $26 per visit for a social worker.

CMHC's emphasize provision of services on an outpatient basis wherever possible. This further reduces the costs of services in CMHCs and for most mentally ill patients is far less disruptive than institutionalization. About 78 percent of CMHC episodes of care are on an outpatient basis and another 6 percent are provided through partial hospitalization (day programs and night care), while only 15 percent are inpatient episodes. This compares to 39.7 percent of patient care episodes provided on an inpatient basis, on average, in other mental health facilities.

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[1] Rittenhouse, J. D., Dept. of Institutions, Colorado. Analysis of Impact of CMHCs on Colo. Stat Hosp. System. PB–213–791 (Dec) 1970.

Rogers, C. W. and Doidge, Jr.: Is NIMH's Dream Coming True? Wyoming Centers Reduce State Hospital Admissions. Comm. Mental Health Journal (Fall) 1975.

Windle, C. and Scully, D.: The Success of CMHCs in Increasing Community Locus of Services. Paper presented at American Psychological Association Convention, Montreal, Canada, Aug. 1973.

National Opinion Research Council: Community Mental Health Centers and State Hospital Utilization. Contract 70–522 (June) 1974.

Herz, M., Spitzer, R., and Endicott, J.: Research in the Delivery of Mental Health, Dis. of New System. 33 :7, 478–80 (July) 1972.

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Schmidt, L. J.: Reducing Reliance on the Psychiatric Hospital: The Utah Experience. Psychiatric Annals, 5 :5, 62–70 (May) 1975.

Langsley, D. C. and Barter, J. T.: Treatment in the Community or State Hospital: An Evaluation. Psychiatric Annals, 5 :5, 7–19 (May) 1975.

[2] Sharfstein, Steven S., M.D., Nafziger, J. Calvin, M.D.: Institutional or Community Care: Costs and Benefits (available from Steven Sharfstein, National Institute of Mental Health).

When CMHC patients are hospitalized, stays are kept to a minimum: 17 days on average compared to 41 days in state institutions and 20 days in psychiatric hospitals.

CMHC's are available to serve all individuals in the catchment area who are in need and under the new legislation referred to above (PL 94–63) must establish and implement a fee schedule based upon ability to pay. Nationally, CMHC's serve primarily low income individuals at this time: 51.8 percent of all patients in 1973 had family incomes under $5,200 and 83.7 percent incomes below $10,400.

Other aspects of the CMHC program which should be mentioned are: The active involvement of the community in the development and operation of the program—by law CMHCs are mandated to involve the community in the development of the program and all CMHCs (other than those operated by government agencies) must be controlled by boards a majority of whom are consumers; CMHC's make maximum use of all mental health professionals and para-professionals and non-professional mental health workers in order to make services more available and to hold down costs; and CMHC programs are required to institute peer and utilization review systems to ensure that all patients receive appropriate treatment and to control unnecessary utilization and costs.

In recent years there have been a number of studies regarding the CMHC program conducted by the General Accounting Office, the House Appropriations Committee investigative staff, the House Health and Environment Subcommittee and the Senate Health Subcommittee staffs, and a Ralph Nader group. Numerous other studies regarding certain aspects of the centers and the federal program have also been undertaken.

While a number of deficiencies in the program have been illuminated by these studies (deficiencies which have been and are being corrected through new legislation or program regulation) the studies have pointed out the value and vital contribution made by these programs.

As the issue of national health insurance is addressed, the experience gained in the CMHC program should not be ignored.

COMMUNITY MENTAL HEALTH CENTERS AS A SYSTEM OF CARE

As mentioned above, one of the most important aspects of the CMHC program is the development of a system of comprehensive care for the mentally ill. It is this aspect, more than any other, which makes the centers a useful prototype for national health insurance planners to examine.

While community mental health centers were devised primarily to bring comprehensive mental health services into the community—to provide a more appropriate alternative to state mental institutions for those unable to meet the costs of care—CMHCs, along with other federally initiated programs such as neighborhood health centers and health maintenance organizations, have the capacity to make substantial changes in the system for delivering health services.

Community mental health centers, for instance, represent a complete system of care for the mentally ill in the community. Each CMHC serves a specifically defined geographic area, and provides a full range of services to all residents in that area.

CMHC's are required by law to ensure that all services are coordinated with the provision of other mental health, health and social services in the community.

This requirement means that in planning CMHC services, agencies are required to review all existing services in the area, to pull these together to the maximum feasible extent into a coordinated program, to make provision for filling gaps in services in the catchment area and to attempt to eliminate unnecessary duplication. CMHCs have developed extensive outreach programs to ensure that all individuals in the catchment area who have need of services are both aware of their availability and encouraged to seek assistance.

The centers preventive programs (consultation and education) include a wide range of indirect services which also help to establish an effective system of mental health care. Through C&E. the centers reach into the schools, health agencies, law and corrections agencies, welfare departments and so on to educate personnel in these agencies about the services of the center and on mental health issues in general so that appropriate individuals are referred to the center for care.

Thus a community mental health center, as defined in federal law, is far more than just another isolated federal health program. This program is designed to make substantial impact on some of the most difficult and pervasive problems in health delivery, such as: Accessibility—both in terms of geography and socio-economic factors; emphasis on preventive care, early intervention and health education; emphasis on ambulatory care and other innovative alternatives to expensive 24-hour a day inpatient services where these services are not in the best interests of the patient; continuity of care and organization of services; utilization of all mental health professionals and paraprofessionals in mental health teams; and elimination of costly duplication of services to the extent this is feasible.

Much discussion in the health planning field now focuses on these very issues. For instance, the Forward Plan for Health developed by HEW includes as major themes such issues as preventive care and health education (long given particular emphasis in the CMHC program); ways to discourage inappropriate hospital stays and to keep all hospital stays short, partly to reduce the costs of federally supported health services (this too has been a major theme in all CMHCs since the initiation of the program); accessibility, and coordination of services to improve continuity of care and eliminate duplication (CMHC's have a unique role to play here in the mental health area).

The Congress, too, is becoming increasingly concerned with these issues. In particular, the recently enacted Health Planning and Resources Development Act is designed to bring about better coordination of services, eliminate duplication and provision of unnecessary services, particularly institutional services.

NHI ROLE IN IMPROVING ACCESSIBILITY, CONTINUITY OF CARE AND COORDINATION AND INTEGRATION OF SERVICES

The problems and deficiencies in the American health care system clearly cannot be simply solved. The influx of enormous amounts of federal dollars through a health insurance system, if not coupled with provisions to improve the delivery system, will greatly inflate health care costs without substantially improving accessibility and availability of appropriate services for most Americans and without greatly improving the health of the American people as a whole.

The federal government should not initiate a nationwide program of direct financing for health services without at the same time continuing and expanding efforts to: Eliminate duplication of services; eliminate unnecessary services, particularly to reduce inpatient care to a minimum and emphasize ambulatory care; emphasize preventive programs and health education; encourage outreach efforts and other programs which ensure early intervention; improving accessibility of all services—this means removing financial barriers, physical barriers and socio-economic bariers to services; emphasize provision of care by all appropirate health professionals and para-professionals to increase availability and to hold down costs; institute cost controls on health care services; expand quality controls through peer review; and improve coordination among existing services.

Some of the pieces to achieve these objectives are already in place. As mentioned above, the Health Planning and Resources Development Act when fully implemented should have a significant impact on the planning of new services and the elimination of unnecessary institutional services, as well as encouraging better coordination among existing health delivery programs. The recently enacted Community Mental Health Centers Amendments of 1975, cited above, also were designed by the Congressional Committees as forerunners of national health insurance and will greatly strengthen many aspects of the CMHC program, including the development of a complete system of mental health care in the community. We understand also that the neighborhood health centers program has been similarly strengthened by recent legislative changes; and the federal health maintenance organization program is also designed to improve coordination and delivery of comprehensive services.

Thus, as a first step, national health insurance should encourage the continued operation of existing federally-supported programs to develop systems of care, such as CMHC's which meet the definition of the new CMHC Act. Full reimbursement should be available to CMHC's for all direct health care services in a manner which facilitates the continued operation of these innovative programs. This would include reimbursement for services provided by all mental health professionals and, when under appropriate supervision, by para-professionals and mental health workers as well as reimbursement for outreach programs and other services (e.g. home health services) provided outside the main center facility.

Under the current law, and for the past ten years, community mental health centers have been available to provide all necessary services to those in need, regardless of ability to pay. If NHI does not provide reimbursement for these same services, this will necessitate either the continuation of the federal categorical grant or the discontinuation of services which are and have for many years been available to low and moderate income families. NCCMHC believes that it would be more efficient and more economical (especially in terms of administrative costs) if all CMHC reimbursements for direct services from the federal government were consolidated into a single program, such as NHI. The continuation of categorical grants to supplement NHI services would be unnecessarily expensive for both the centers and the federal bureaucracy.

In addition to providing reimbursement for community mental health centers and other systems of care, NHI needs to do more in the mental health area to strengthen the current uncoordinated and scattered mental health delivery system. First in all communities all existing mental health providers (both agencies and private practitioners) should be required to develop formal affiliation agreements to facilitate quick and easy referral of patients between various providers. Experience with the CMHC program points out very vividly the need for formal agreements between providers if real cooperation and coordination is to be developed. CMHCs have found that only where they have written agreements with other providers is there a real attempt to streamline administrative issues (record keeping, etc.), to provide effective linkage for follow up care of patients referred and to ensure continuity of care for all patients. Effective affiliation agreements also require some regular interactions between the staff of the agencies concerned.

Informal affiliation agreements, on the other hand, frequently mean that patients are referred to another agency but no one ensures that the patient actually is seen by that other agency, there is no system for the referring agency to follow up and provide care, if required, at a later date, records are lost or never forwarded, and the patient is left to find his own way through the maze of available services.

NHI can strengthen the delivery of mental health services by requiring: Formal affiliation agreements between all providers, practitioners and community mental health centers serving a given federal catchment area; and in areas with no CMHC, formal affiliation agreements between hospitals, private practitioners, specialized treatment services, etc. under which agreements every patient will have access, through the provider he first contacts, to the complete range of services covered under NHI.

Other initiatives needed in NHI are: A system of peer and utilization review with national guidelines designed to eliminate inappropriate inpatient and institutional care of the mentally ill; reimbursement for outreach and other case finding activities of providers; a system of reimbursement which ensures that mental health care consists of active treatment (additional services such as education, vocational rehabilitation, and custodial services may be appropriate for the patient, but they should be funded through some other mechanism, not through NHI); and a system for ensuring that the federal government has control over the reimbursements for mental health and other health services to ensure that such reimbursements are reasonable, and arrangements for prospective reimbursement of provider agencies so as to encourage efficiency.

The incorporation under NHI of these initiatives would enable the federal government to not only remove the financial barriers to mental health services but also to strengthen the system of care by making existing services more accessible and by encouraging appropriate treatment of the mentally ill. In writing the details of an NHI bill, however, there are a number of problems which have been highlighted by existing federal reimbursement programs, particularly Medicare, which the Committee should be aware of.

CMHC PROBLEMS UNDER EXISTING FINANCING PROGRAMS

Current federal third party payment programs for health services—Medicare and Medicaid—do not facilitate support for services provided through community mental health centers. Although a number of centers are able to participate under these programs in many instances they are inappropriately classified (as psychiatric hospitals) or receive reimbursement for services provided by individual members of their staff based on a fee-for-service rate. Provider reimbursement through Medicare, for instance, is not available for about 80 percent of CMHC's.

The cause of the problem is the emphasis under Title XVIII, and to a lesser extent Title XIX, on services provided through traditional institutions (hospitals, nursing homes) and through private practitioners. The centers program, which has grown in scope to a substantial program at this date, was not operational when Title XVIII was first written. No amendments have yet been made to include the centers because federal categorical funding was available.

Now that federal categorical funding is terminating for a number of centers which have reached the end of their eight years of federal support, the issue of Medicare coverage has become critical, and NCCMHC has proposed amendments to Title XVIII to enable community mental health centers which meet federal standards to participate as providers and to receive reimbursement for mental health services provided under appropriate conditions. This would include reimbursement for all services provided by mental health professionals, not only the services provided by or under the direct supervision of physicians, as under the current law. Materials relating to the problems facing CMHC's under Medicare have been presented to members of the committee, together with NCCMHC's proposals for amending the law.

Our experience under Medicare points out several issues which need to be addressed as a comprehensive system of national health insurance is devised.

As emphasized above, NHI must include incentives for the continued operation of a system of care such as CMHC's and related provisions to improve the health delivery system in areas where comprehensive programs have not been established.

In order to encourage the continued operation of CMHC's based upon our experience under Medicare, it is essential that community mental health centers be given provider status under NHI. This would enable reimbursement on the basis of cost (either based on reasonable costs for services or prospective reimbursement depending upon the mechanism proposed for other providers), and enable CMHC's to support all their direct service programs through national health insurance.

A related and vital issue is the coverage of the services which CMHC's provide. The restriction in Medicare which limits reimbursements to physician-directed services essentially wipes out many center services. For instance, many rural centers are unable to employ a full time psychiatrist. When the part-time physician is not working in the center, none of the services provided are reimbursable under Medicare. Most centers operate through numerous disparate facilities in the community to improve accessibility—while a physician is available in the main center facility it is impossible for the centers to employ physicians in all of their satellite program elements. Again, Medicare reimbursement is denied in these instances.

Nationally, there is a serious shortage of psychiatrists, and this shortage is expected to worsen. Requiring physician-direction of all services would encourage provision of services by a physician when the service could equally effectively be provided by some other professional at less cost, and secondly deny reimbursements, and therefore in many instances services, because a qualified physician is simply not available to provide the service.

Thirdly, any system of national health insurance which covers the services provided through community mental health centers should be designed to tie in with related federal initiatives in this field. The Community Mental Health Centers Amendments of 1975 (Title III, PL 94–63) established a comprehensive definition of a community mental health center. This definition outlines: The twelve services which all community mental health centers should provide or should ensure are provided in the community in a coordinated fashion; the governing structure of the CMHC; the peer and utilization review mechanism which must be established to ensure quality of care and to control costs; the ongoing involvement of the community in the activities of the CMHC which should be part of any CMHC program: and other administrative and operational requirements which the center must meet, including several which are identical to those for hospital and other providers under Medicare.

NCCMHC therefore recommends that in writing a comprehensive national health insurance measure, the Committee include coverage of the direct services provided by community mental health centers (as outlined in the section above) and further that: CMHC's be specifically listed as providers of care; CMHC's be defined under NHI as those entities which meet the definition of a CMHC in the

Community Mental Centers Act (further standards could also be set, but the established federal definition should serve as a basis for meeting NHI requirements); and coverage of services provided by CMHC's specifically include the services provided by all mental health professionals or under their direction in order to continue the current emphasis in centers of full utilization of all available manpower.

CONCLUSION

Thus NCCMHC recommends the development of a national health insurance measure which will encourage the development of systems of mental health care by:

Requiring effective and formal linkage between all mental health providers in the area or community, including CMHCs (if established), hospitals, private practitioners, specialized treatment programs and services, etc., to ensure that every patient has direct access to all covered services through the provider he first contacts.

Replacing the federal categorical grant as the funding mechanism for CMHC's which meet federal standards (as spelled out in the Community Mental Health Centers Act).

Specifically including CMHCs which meet federal standards as providers of care under NHI, and including as covered services all CMHC services provided by mental health professionals and, under appropriate supervision, by paraprofessionals and other mental health workers, whether provided in the main center facility or elsewhere.

Instituting a system of peer and utilization review with national guidelines designed to eliminate inappropriate inpatient care for the mentally ill.

Reimbursing outreach and other case finding activities of mental health providers.

Setting up a system of reimbursement which ensures that mental health care consists of active treatment only.

Setting up a system to ensure that the federal government has control over reimbursements for services to ensure that reimbursements are reasonable, and providing arrangements for prospective reimbursement of provider agencies so as to encourage efficiency.

Mr. ROSTENKOWSKI. Mr. Williamson?

STATEMENT OF WRIGHT WILLIAMSON

SUMMARY

1. Clinical Social Workers are not included in any proposed National Health Insurance legislation as primary health service deliverers.
2. Clinical Social Workers in the mental health field provide more direct services than psychologists and psychiatrists combined.
3. Clinical Social Workers provide services to a broader range of the total population than do psychologists and psychiatrists.
4. Clinical Social Workers are intensively trained through four years of academic and supervised experience in clinical settings to provide psychotherapeutic services.
5. Clinical Social Workers maintain high professional standards through the use of effective Peer Review models and through participation in Professional Standards Review Organizations.

For these reasons, Clinical Social Workers should be included in any National Health Insurance legislation made available to the citizens of the United States.

Mr. WILLIAMSON. Thank you, Mr. Rostenkowski.

My name is Wright Williamson. I live at 4401 Elm Street in Chevy Chase, Md., and my office is at 7979 Old Georgetown Road in Bethesda, Md. I am the executive director of the National Federation of Societies for Clinical Social Work, and I am a professionally trained clinical social worker in private practice in Maryland. I appear before you today as a representative of the National Federation of Societies for Clinical Social Work and its constituent State societies in 19 States across the Nation.

FAILURE TO INCLUDE INDEPENDENT CLINICAL SOCIAL WORKERS IN PROPOSED NATIONAL HEALTH INSURANCE

The members of the federation are most concerned that clinical social workers are not included as independent health care providers in any of the national health insurance legislation presently under consideration. Rather, social workers are included in some legislation as providers as part of the services rendered in hospitals. No provisions exist for outpatient services even though it has been nationally recognized that qualified social workers provide a reasonable alternative to the more expensive services of psychologists or psychiatrists.

The inclusion of clinical social worker services as part of the services rendered in hospitals provides another opportunity for the hidden costs so frequently found in large institutions. It has been virtually impossible to break out the actual costs of clinical social work services in comparison to the amount collected from third-party carriers. Freeing clinical social workers from institutional control will render a much more accurate picture of the actual costs of services.

DEPTH OF CLINICAL SOCIAL WORK SERVICES

In a number of studies published by the National Institute of Mental Health on mental health manpower it has been pointed out that clinical social workers in the mental health field provide more direct services than psychologists and psychiatrists combined. It seems strange that none of the health insurance legislation currently under consideration give attention to this fact.

This failure is even more significant when it is remembered that the funding for public and private mental health services depend more and more on third-party payers. One can only wonder why insurance carriers are willing to reimburse for the typically more expensive services of psychologists and psychiatrists while disallowing the less expensive services of qualified clinical social workers. This practice, and its support by existing national health insurance proposals, discriminates against the major professional providers of service, the clinical social workers, and inflates the costs of mental health services.

BREADTH OF CLINICAL SOCIAL WORK SERVICES

The same manpower studies noted above also point out the much broader availability of clinical social workers across the Nation. The spread of clinical social workers more closely approximates the population density of the United States than the spread of either psychologists or psychiatrists. It is clear, therefore, that clinical social workers are more willing to provide services outside the heavy population clusters of the Nation than are psychologists or psychiatrists.

CLINICAL SOCIAL WORK TRAINING

Clinical social workers are among the best trained of the mental health professions. To qualify for membership, at least in the organization of which I am executive director, a person must have a master of social work degree and, in order to be recognized as an independent practitioner, must have had at least 2 years of supervised experience in a clinical setting. The academic program for a masters of social work degree requires 12 months of course work and 12 months of closely supervised parallel experience in a clinical setting. In point of fact, therefore, the clinical social worker recognized by the federation as prepared to offer independent services will have had 4 years of intensive training.

Clinical social work training includes the development of expertise as individual and group therapists. The theories and techniques of psychotherapy have been reworked for use by clinical social workers in their services to individuals, groups, married couples, and families.

PEER REVIEW AND PSRO INVOLVEMENT

The Federation of Societies for Clinical Social Work has developed a set of standards for peer review which allows the consideration of questions raised by patients, the relatives of patients, third-party carriers or members of other care-giving professions. The peer review mechanism is designed to provide a response within 30 days of receipt of a question and it safeguards the anonymity of both the patient and therapist. Appeals from decisions are possible and sanctions are imposed upon those whose competence is found to be questionable.

The federation has developed "Standards for Health Care Providers in Clinical Social Work." These standards were established at the initiative of the federation in recognition of the responsibility of clinical social workers to support the work of the congressionally established Professional Standards Review Organizations (PSRO). Though PSRO's are mandated as medical institutions, the regulations require review by one's own peers. Clinical social workers have moved to accept that responsibility at every level of review.

We believe all the above facts describe the efforts of a profession to regulate itself to provide a uniformly high level of service. Moreover, it has been repeatedly demonstrated that a very large portion of the mental health services offered in the United States are actually delivered by clinical social workers.

We respectfully request your inclusion of clinical social workers on the same level as any other health care profession in any national health insurance legislation offered to the citizens of the United States.

I have attached supporting material to this brief testimony, sir.

Thank you.

[The material follows:]

FACT SHEET

(Re participation of clinical social workers historically in the mental health and health care delivery system of the United States)

1. Social workers are presently providing most of the direct mental health services in the United States. As of January, 1970, 15,257 social workers were employed in psychiatric facilities throughout the country. Of these, 11,000 hold a Master's degree or higher. In examining the personnel staffing of the free-standing outpatient psychiatric clinics in January, 1970, one finds more social workers (5,461) than any other profession; and, there are more full-time social workers than psychologists, psychiatrists and all other physicians combined: 3,014 social workers to a total of 2,042 for the other three professional categories combined. (Source: *Health Resource Statistics:* 1971, Chapter 30.)

2. In a comparison of the distribution of staff time, by discipline, in selected inpatient psychiatric facilities and in free-standing outpatient psychiatric clinics, statistics show that social workers again were spending more professional time giving service at these facilities than the combined time of the psychologists and psychiatrists combined), but maintain that position in *every* setting measured—in State government, local government and in private (voluntary) non-profit settings. (Source: N.I.M.H., "Staffing of Free-Standing Outpatient Psychiatric Clinics." *Statistical Note No. 56*, August, 1971. Pages 5 & 11.)

3. In counting the number of social workers in all transitional facilities serving the mentally ill in the United States (January, 1970) one again finds social workers as the principal providers of mental health service. Not only do they provide more total staff than the two sister professions, in addition, professional full-time social workers represent more than six times the total of all full-time psychiatrists, psychologists and other physicians combined. (Source: *Statistical Note No. 28*. October, 1970, Page 4.)

A further HEW study, this time of state and county mental hospitals, shows that in percentage distribution of time allotted for patient care, social workers exceed psychiatrists, and spend more than twice as much time relative to psychologists. Once more, social workers prove to be the principal providers of mental health care. (Source: N.I.M.H., "Staffing of State and County Mental Hospitals: 1970." *Statistical Note No. 52*. June, 1971, Page 20.)

Finally, a detailed study of the number of full-time staff in the 205 operational, federally-funded community mental health centers around the country—in 44 states and Puerto Rico—shows that social workers are the primary mental health providers (2,037 workers), again more than the combined total of full-time psychologists (955), psychiatrists (769) and other physicians (74) combined, (with each center averaging 8 full-time social work personnel.) (Source: N.I.M.H., "Preliminary Data on Staffing Patterns in Federally Funded Community Mental Health Centers." January, 1971, Mimeo, Tables 1 & 6.)

A careful examination also has been made of family service agency personnel. According to FSAA survey statistics (1967), there were 3,072 caseworkers alone giving direct service, approximately 90 percent of whom had completed graduate social work education. Moreover, in supervisory positions (supervisor to executive director) there were another 1,010 social workers, approximately 96 percent of whom were professionally trained. (Source: Livia Lowy, *Characteristics of the Professional Staff of FSAA Member Agencies:* January 1, 1967, (N.Y.: FSAA, 1968), Tables 1 and 19.

Finally, an examination has been made of child welfare agency personnel. According to CWLA survey statistics (1972), there were 1,853 social workers with full professional credentials giving direct service, as well as some 1,321 social workers in supervisory positions (supervisor to executive director.) (Source: Michael J. Smith, *Salary Study: 1972:* Child Welfare League of America, 1972, N.Y.), Table 2.

4. Discrimination Against Classes of American Citizens: In general, social workers provide services to all strata of society, but primarily to the middle class and the poor. Their professional services are provided to every type of person subject to personal or social trauma; including the medically, emotionally and mentally ill, juvenile delinquents and adult criminals, the socially maladjusted, the educationally handicapped, economically distressed and others.

A key problem in the delivery of health care services in the United States is the maldistribution of professional personnel, both geographically and by economic and ethnic class. Examination of this phenomenon demonstrates that social workers provide radically greater amounts of service in the areas served to a lesser degree by physicians and psychologists.

The American Psychological Association reports that practicing psychologists are concentrated disproportionately in high population states and urban areas, which tends to be a situation common to all three professions. But they differ in the extent of the concentration. For example, New York and California contain the most practitioners in all three professions, but while 36 percent of psychiatrists and 33 percent of psychologists are found there, only 26 percent of social workers are in these two most populous states—a small but significant difference if one realizes that the difference of 10 percent between the psychiatric and social work professions represents some 5,500 social workers available to other parts of the country.

A study has also been done of the availability of mental health services from the three professions in three relatively poor and remote areas of the country. The results are as follows:

States	Availability of professional—		
	Psychiatrists	Psychologists	Social workers
Deep South:			
Louisiana	231	188	966
Mississippi	54	88	155
Total	285	276	1,121
Remote States:			
Alaska	13	24	81
Hawaii	73	114	367
Total	86	138	448
Central plains:			
North Dakota	25	51	127
South Dakota	16	37	98
Total	41	88	225

Source: Beatrice Phillips, "Social Workers in Health Services" in "Encyclopedia of Social Work", National Association of Social Workers, New York, p. 568.

While it is difficult to get comprehensive data on characteristics of population served, it would appear that social workers—because of their strategic location in community mental health centers throughout the country, their greater geographic dispersion (especially to states with a greater number of low-income and minority populations), their availability in OEO and anti-poverty funded programs, and their willingness traditionally to serve in intercity settlement houses and community centers—are giving a disproportionate amount of service to those most neglected by the sister professions. Therefore, it might be argued that any expansion and codification of service under a national health insurance plan consciously would be neglecting the mental health needs of that one-fifth of the Nation still living in poverty and deprivation if it were to bypass social workers as full and equal participants in service provision.

In this regard, it can be argued that present state and federal policies which effectively exclude social workers from delivering mental health care under Medicaid are a form of class discrimination, since the Medicaid program is specifically directed to serve the poor. In short, the result of these governmental policies may be that mental health services simply are not being given to a whole sector of the lowest income citizens in the country, for surely the few available psychologists and psychiatrists are not serving today the mental health needs of the more than 10 million people covered under Title XIX.

5. The economic effects of failure to include legitimate social work services in a private or public health care insurance are to maintain a semi-monopoly on therapeutic services provision, which, in view of the tremendous need, continues to escalate the costs of health care services. The restriction to medical supervision of social workers maintains a single entry to health care services which does not allow patient choice and produces a barrier to the early casefinding that is important to preventive service.

Social workers are and will be used for carrying important components of the therapeutic process, particularly those problems which relate to adequate social adjustment. The economic effect of the intervening one-way professional screening of patients is to escalate costs and to prevent the screening process by social workers which moves patients with disorders best treated by phyicians and psychologists to those professions for service.

6. In the "Employees Benefit Plan Review", Research Reports, 325, 3–17, 6–72 Revision, there is a report entitled, "Psychiatric Benefit Reduces Use of Medical Services: 30 Percent Reduction in Visits for Physicians and Ancillary Services." Studies were conducted separately by the Group Health Association of Washington, D.C., The Kaiser Foundation Health Plan in Northern California, and the Health Insurance Plan of Greater New York.

7. A book entitled, "The Fifth Profession: Psychotherapy," reports a comprehensive study of psychiatrists, psychologists and social workers and finds more similarities between what they do than dissimilarities. The U.S. Public Health Service Bulletin, "Improving Mental Health Coverage", 1965, says "Increased recognition should be given to all professional skills essential to treatment and rehabilitation. . . . Both the continuing development of the mental health treatment team and the present shortage of mental health professionals argues strongly for covering the services of all mental health disciplines, including the clinical psychologist, the psychiatric social worker, and the psychiatric nurse."

Clinical Social Work Peer Review Committee

1. A Clinical Social Work Peer Review Committee shall be elected or appointed by each Society.

2. The Committees will be made up of nine members. Only social workers who are eligible for acceptance for the Registry may serve on the Committee.

3. It is suggested the Committee, where possible, be made up of representatives from each of the following: local public and/or private agencies and Social Workers in private practice. All members shall be directly involved in the provision of clinical services on a fee-for-service basis.

4. By maintaining the highest standards of practice, the Clinical Social Work Peer Review Committee will also serve an educational function for the public, for the profession, and for insurance carriers.

The Committee's responsibility for the maintenance of the highest possible level of clinical practice shall be exercised through its peer review function. Each Committee must institute a mechanism through which it can deal with any issues of clinical social work practice brought to its attention by a "patient", a "patient's" family, a representative of a third-party carrier, another social worker, or a member of another care-giving profession. The following is suggested as a useful model.

(The CSWPRC must assure that all parties concerned with an issue are given every opportunity to present facts bearing on the resolution. The rights of all parties to confidentiality must be protected. With these considerations in mind, the following mechanism for review is suggested.)

1. Potential questions for the CSWPRC shall be addressed in writing to its elected Chairman. On receipt of a question the Chairman will decide if the issue should be addressed to the CSWPRC. If not, the Chairman will immediately notify the party raising the question of the name and address of the person to whom the matter should appropriately be directed. If it is decided the question is a matter for the CSWPRC, the Chairman will immediately advise both the party raising the question and the social worker involved of acceptance of the issue for review. The social worker will be asked to respond within ten days and to describe in detail the kinds of services provided, the frequency of visits, the length of the interviews, and the fees charged for these services.

2. Upon receipt of this material from the respondent, the Chairman will, within ten days, request a review of the material by three members of the CSWPRC selected as representative of the respondent's specialty, knowledgeable of the setting within which he functions, and of comparable experience. All identifying information will be deleted from the material directed to the three members of the CSWPRC. The Chairman will notify all members of the CSWPRC of a meeting to vote on the question. This meeting will be scheduled two weeks from the date the material is distributed to the three-member panel.

3. The three selected members will be responsible to report their opinions to the full membership of the CSWPRC.

4. The membership of the CSWPRC will vote on the question; the Chairman will vote only in the event of a tie.

5. The Chairman will notify both the person bringing the question and the respondent of the findings of the CSWPRC within five days of the date of the meeting.

6. In the event of an adverse decision, the respondent may request a review by the CSWPRC within 30 days. If the decision of the CSWPRC is sustained, the person may finally appeal within 30 days of the date of the decision of the local CSWPRC to the Executive Committee of the local Society for Clinical Social Work.

7. The local CSWPRC shall be responsible to establish through surveys local, usual and customary fees and methods of practice.

STANDARDS FOR HEALTH CARE PROVIDERS IN CLINICAL SOCIAL WORK

(National Federation of Societies for Clinical Social Work, Professional Standards Review Committee)

HISTORY AND BACKGROUND

The Professional Standards Review Committee (P.S.R.C.) was established by the National Federation of Societies for Clinical Social Work to create a model set of national standards for providers of clinical social work services and a peer review system to serve the needs of providers and consumers of clinical social services, third party payers, and governmental agencies.

Over a six month period, beginning in May, 1974, the P.S.R.C. has convened in Chicago, Washington, D.C., and New Orleans, for intensive work sessions to complete a model set of national standards for clinical social work practice. The committee has maintained liaison with the Department of Health, Education, and Welfare, The American Psychological Association, The National Association of Social Workers and other professional and governmental organizations and agencies interested in standards for clinical social work services and peer review. The primary objective of these standards is to provide guidelines for the clinical social worker who is qualified to provide autonomous health care services, and to identify the qualified clinical social worker as an independent, primary provider of health care services. If clinical social workers expect to be included as independent providers of health care services by insurance carriers and expect to be included in National Health Insurance, standards for clinical practice and a functioning peer review process must be developed and implemented.

PREAMBLE

Three standards for clinical social work services project and anticipate comprehensive health services including mental health services and other health care services provided by clinical social workers as the accepted right of every individual to the extent to which the individual desires and is willing to accept those services. The frame of reference of this set of standards is a global, mobile society, characterized by longer life with fewer major physical health problems, extended leisure without economic need, and a society whose survival and prosperity will depend in large measure on creative functioning at a maximum level with dedication to the highest human ideals. Only if so equipped will our country be able to extend in the area of democratic ideals the world leadership it has achieved to date in the economic and industrial spheres.

With the emerging of P.S.R.O. and national health insurance, clinical social work practice has a mandate to establish standards of accountability. The procedures necessary for effective peer review demand that clinical social workers establish principles of quality practice. It will require task and goal specification so that assessment of outcome can be effectively measured and evaluated.

The task of establishing standards for providers of clinical social work services is monumental. There are numerous theories for personality development and treatment procedures, systems, and modalities. Consumer participation demands are becoming important with emphasis on accountability with the consumer no longer the "captive" of the established social institutions.[1]

PRINCIPLES

Throughout this monumental task of developing a set of model standards for clinical social work services, the committee has followed a number of principles which are reflected in the Standards that follow.

These principles include:

1. There must be a single set of Standards for all clinical social workers in all human services and health care settings for the guidance of all concerned parties.

These concerned parties include:

a. The providers of services (i.e., clinical social workers and their support staff).

b. The consumers of services (i.e., patients, clients, organizations, industries).

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[1] Golton, Margaret, D.S.W., Standards and Guidelines for Peer Review of Mental Health Intervention by the Autonomous Clinical Social Worker, unpublished manuscript, Cleveland, Ohio, 1974.

c. The sanctioners of services (i.e., the general public, governmental agencies, third party vendors, accreditation groups).

The provider of health care services in clinical social work must be guided by a single set of standards in a variety of settings. Standards for the practice of clinical social work restrict the provision of services to professionals who are qualified by objectively defined systems operating within guidelines to assure that quality services reflecting excellence are provided to the consumer of such services.

2. There must be a single uniform set of Standards covering the provision of health care services in clinical social work to consumers of services in both the private and public sectors. Equal safeguards should be available to consumers of services in both private and public settings including peer review, standards of excellence and supervision or consultation.

3. The health care clinical social worker[2] is defined as a social worker who: has a Master's or Doctor's degree in Social Work from a school of social work accredited by the Council on Social Work Education with a sequence of clinically oriented course work and supervised clinical field placement, the master's degree program must be a minimum of eighteen (18) months, or its demonstrated equivalent, and two years, or its equivalent, of post-master's or doctoral full time supervised direct service clinical experience in a clinical setting.

4. Upon implementation of the National Registry of Health Care Providers in Clinical Social Work, all clinical social workers who meet the criteria should be registered thereunder.

5. These standards must assure the consumer of the clinical social workers' accountability for the quality of services received. Standards must be flexible to the point of allowing the clinical social worker to employ innovative methods of clinical services and flexible use of para-professional personnel who provide services under his/her supervision.

6. The standards must recognize and provide for emerging changes in clinical social work delivery systems and patterns.

7. The clinical social worker provides services to a potential patient independently of that patient's race, color, religion, sex, or national origin.

8. The clinical social worker has the right to limit his practice.

RATIONALE FOR STANDARDS

The Professional Standards Review Committee has been acutely aware of certain implications implicit in the task of establishing standards for clinical social work services. "Standards" as defined by P.S.R.O. (The Office of Professional Standards Review, D.H.E.W.) refer to the range of acceptable variation from a norm or criterion.[3]

We may expect difficulty in determining "acceptable variations," thus acceptable to whom might be a pertinent question. With the burgeoning of the consumer rights movement, the provider must be clear as to the responsibility he is undertaking when he accepts an individual (family) for service; what conditions are necessary for his fulfilling that responsibility (length of time of treatment, frequency of appointments, setting, etc.) and what requirements or responsibilities belong to the patient under care.

Standards should provide the basis for a clear understanding between the clinical social worker and the consumer with an understanding of services to be provided, fees, and the availability of peer review for disputed claims and consumer complaints.

Standards should be a necessary initial step toward more uniform legislative and regulatory (licensing) programs for clinical social workers.

Standards should have a significant impact on improving graduate educational training in clinical social work.

Standards must be realistic and will require continuing review and revision.

With these implications considered by the Professional Standards Review Committee, a set of national standards for health care providers in clinical social work practice have been established which are simple and concise with the focus on upgrading the quality, and accountability of clinical social work services. It is the intent of the Standards to improve the delivery of clinical social work services in whatever the setting.

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[2] All subsequent references to clinical social worker refer to the health care clinical social worker as defined in this paragraph.

[3] P.S.R.O. Program Manual, U.S. Department of Health, Education, and Welfare, Office of Professional Standards Review, Rockville, Maryland, 1974.

These Standards serve to establish acceptable levels of clinical social work services. They also serve to establish objective and consistent means for evaluating the performance of individual providers and to guide the proper organization of clinical social work services in health care facilities.

The clinical social work profession's concern for the quality of its services constitutes the heart of its responsibility to the public and consumers of such services. The clinical social work profession must seek control of and accountability for its practice to guarantee the quality of services to the public. With the confidence of the public and recognition of expertise in providing essential health care services, the clinical social work profession will continue as a vital health care resource.

STANDARDS

1. *Definitions*

1.1 The term "provider" refers to the following persons:

A. The health care provider in clinical social work is defined as a social worker who: has a Master's or Doctor's degree in Social Work from a school of social work accredited by the Council on Social Work Education with a sequence of clinically oriented course work and supervised clinical field placement. The Master's degree program must be a minimum of eighteen (18) months, or its demonstrated equivalent, and two years, or its equivalent, of post-master's or doctoral full time supervised direct service clinical experience in a clinical setting.

B. A social worker who does not meet the requirements of section A performs services under supervision of a qualified clinical social worker.

C. A person offering services which are primarily social work in nature in a health care facility requires supervision by a qualified clinical social worker.

1.2 The term "Clinical Social Work Facility" refers to, but is not limited to, one or more of the following:

A. A clinical social work section in a facility, institution, organization, agency, education, government, or industrial concern.

B. Clinical social work services provided as part of, or a subdivision of, a facility, institution, organization, agency, business, educational, or industrial concern.

C. Clinical social work consultation provided by a qualified clinical social worker to an individual, a facility, institution, organization, agency, educational, business or industrial concern.

D. Practice in an individual or group private practice.

1.3 The term "clinical social work practice in health care" refers to, but is not limited to one or more of the following:

A. The evaluation and treatment of disability resulting from the emotional stress due to physical illness.

B. Assisting medical and other health care staff in planning for appropriate treatment of patients based on the clinical social workers awareness of family disfunction that interferes with appropriate use of community resources.

C. Assisting medical and other health care staff in arranging for alternative medical treatment based on the clinical social workers knowledge of community resources.

D. The evaluation and treatment of stress resulting from family disfunction as well as social, economic, and community disfunctions that impinge on patients ability to recover from physical illness.

E. Helping patients suffering from chronic or terminal illness to function within the limitation of that illness by the use of psychotherapeutic modalities.

F. Arranging discharge planning for patients based on the knowledge of, and skill in utilizing community resources.

G. Placement of medical or psychiatric patients in appropriate level of out of home care. Assisting the patient and his family in adapting to that treatment plan and monitoring his care throughout placement and making replacements when necessary.

H. Skill in helping patients adapt to demands of daily living in recovering from illness.

I. Evaluation and treatment of emotional disorders and mental illness.

J. Skill in helping persons with conscious and unconscious conflicts in relation to the total emotional and social environment in which they must function, through professional help which includes but is not limited to individual, marital, family and group psychotherapy and counseling.

K. Program development services toward upgrading of patient care rehabilitation including training of staff in human growth and development, and the designing of programs to emphasize the emotional and social components of illness and disease.

1.4 The term "Consumer" refers to:

A. Recipient of clinical work services, such as an individual, family, or group.

B. An organization or agency utilizing clinical social work services.

C. Public or private facility utilizing independently offered clinical social work services.

D. A facility employing clinical social workers as consultants.

E. Purchaser—a person or organization who pays for the delivery of clinical social work services, (e.g. a HMO), but who are not recipients of services. This also includes third party payers.

1.5 The term "Sanctioners" will be in accord with the definition which is provided by P.L. 92–603.

2. *Providers*

2.1 Each setting where clinical social work services are provided shall have on the staff or as a consultant at least one qualified clinical social worker.

Interpreation.—The standard (2.1) refers to the level of training and experience required for independent providers of clinical social work services. All clinical social workers who do not meet the requirements of Standard 1.1.A must work under the supervision of a qualified clinical social worker. Listing in the National Registry of Health Care Providers in Clinical Social work may be utilized to identify qualified clinical social workers in the health services field.

2.2 Where clinical social work services are provided, a qualified clinical social worker shall be responsible for planning, directing, and reviewing the provision of clinical social work services.

Interpretation.—This qualified clinical social worker has the responsibility to recruit staff, direct training and research programs, maintaining a high level of professional and ethical practice, and coordinate the activities of the clinical social work service with other professional and technical groups both within and outside the facility.

When such a qualified clinical social worker is not available on a full time basis, the facility shall retain the services of a qualified clinical social worker on a consultant basis. The clinical social worker so retained shall have the authority and participate actively in the facility's program to enable him/her to assess the needs for services, review the content of services provided, and assume professional responsibility and accountability for them.

2.3 The clinical social worker will utilize his professional training and skills through participation in the development and delivery of clinical social work services.

Interpretation.—Qualified clinical social workers are expected to participate actively in the maintenance of high standards in professional practice through representation on committees such as facility peer review committees concerned with the quality of health care service.

3. *Programs*

3.1 Organization of Clinical Social Work Service:

3.1.1 The delivery of clinical social work services shall be organized to facilitate the optimal care of each patient or development of each facility.

Interpretation.—Clinical social work services should be responsive to the unique needs of the patients or settings served with emphasis on the effective and economical delivery of services. The organization and utilization of services will vary depending on purposes, settings, and the characteristics of the patient population but there must be emphasis on developing and implementing needed services to facilitate the optimal development of patients.

3.1.2 A description of the organization and the lines of responsibility, and accountability for the delivery of clinical social work services shall be available in a written format.

Interpretation.—This description should include lines of responsibility, supervisory relationships, accountability and the process of peer review for each professional who provides clinical social work services.

3.1.3. A Clinical Social Work Service shall include a sufficient number of qualified clinical social workers and paraprofessional personnel to achieve its goals, objectives, and purposes.

Interpretation.—The setting and the type of clinical social work services required and the specific goals and objectives of the facility will determine numbers of qualified clinical social workers and paraprofessional personnel.

3.2 Policies:

3.2.1 In facilities in which clinical social work services are provided, a written statement of objectives and scope of services shall be developed and maintained.

Interpretation.—The objectives and scope of clinical social work services should be reviewed and revised as necessary to assure that the clinical social work services provided are consistent with current clinical social work knowledge and practice. This written statement of objectives and the scope of services should be made available to all staff, and sanctioners.

3.2.2 In the delivery of clinical social work services, the provider must uphold and affirm the legal and civil rights of the patient and adhere to the ethical standards of clinical social workers.[4]

Interpretation.—The clinical social worker must recognize and support the legal rights of consumers of services appreciating the ramifications of report data, disclosures, and other information obtained in the course of providing clinical social work services. The clinical social worker shall be sensitive to the issue of confidentiality of information, the short and long range impact of decision and recommendations, and other matters pertaining to individual legal and civil rights. Providers of clinical social work services should make themselves available to participate on local committees, review boards and other advisory groups established to safeguard the human, civil and legal rights of patients.

3.2.3 All providers of clinical social work services shall conform to relevant statute established by federal state and local governments.

Interpretation.—All providers of clinical social work services shall be familiar with appropriate state statutes regulating the practice of clinical social work in such states where laws have been enacted. They should also be aware of the P.R.S.O. regulations and other governmental or accrediting body regulations which relate to the delivery of clinical social work services.

3.2.4 Providers of clinical social work services shall inform themselves about and utilize the network of human services in their communities in order to effect linkage of participants with relevant services and resources.

Interpretation.—All clinical social workers should be sensitive to the broad context of basic human needs and make available to their patients/clients available information regarding human services such as legal aid, welfare services, vocational and employment sources, health resources, etc. The clinical social worker shall actively intervene on behalf of the patient/client when necessary.

3.2.5 Clinical Social Workers shall maintain a current knowledge of scientific and professional information which is directly related to the services they render.

Interpretation.—Clinical social work providers should regularly participate in continuing education, work shops, participation in staff development programs and keep current with clinical social work and other professional publications. In states where licensing laws exist, mandatory completion of continuing education programs should be necessary for re-licensure. Also for inclusion in the national registry, clinical social workers should have to complete a minimum number of continuing education programs every three years.

3.2.6 In the delivery of clinical social work services, providers shall maintain a continuing cooperative relationship with colleagues, co-workers and allied professionals.

Interpretation.—The clinical social worker has the responsibility to understand the areas of competence of related professionals and make full use of other professional, technical and administrative resources which serve the best interests of the consumer.

3.3 Procedures:

3.3.1 There shall be written service delivery plan for every patient/client for whom clinical social work services are provided.

Interpretation.—A written plan will vary with the setting and the particular needs and problem(s), set priorities among established goals, and outline procedures for implementation of the treatment plan. Such a written plan should provide for subsequent peer review, and other methods of accountability. The written plan should describe the clinical social work services needed and the plan for the delivery of services. Full consent should be obtained from the patient based on the mutual acceptability of the proposed treatment plan.

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[4] See Appendix.

3.3.2 Each clinical social work service shall develop written procedures for the delivery of clinical social work services.

Interpretation.—These statements should describe the current methods, procedures, and techniques to achieve the objectives and goals of clinical social work services. This statement should be written in language that can be understood by patient/clients as well as by providers.

Such a statement should include procedures for making appointments for clinical social work services, including eligibility for services, fees, and priorities of appointments; (a) definining emergency situations and how they are handled; (b) the procedures for referral to other professionals or agencies and the conditions under which such referrals may be made; (c) the sequence of accountability and peer review when there are disputed claims and consumer complaints.

3.3.3 Accurate, current, and complete documentation shall be made of clinical social work services.

Interpretation.—Patient records of clinical social work services should include, but not be limited to, identifying data, a list of problems, date of service, types of service, progress notes, and significant actions taken. The Problem Oriented Medical Record model or a variation of the method is useful for peer review.

3.3.4 Providers of clinical social work services shall establish a system insuring the confidentiality of records.

Interpretation.—Clinical social workers are responsible for maintaining the confidentiality of information in patient records. All persons supervised by clinical social workers, including nonprofessional personnel and students, who have access to records shall be instructed concerning the confidentiality of records.

Unless ordered by a court order, the clinical social worker must not release confidential information, except with the written consent of a patient. Any use of reports, records, or data for research or training purposes shall be consistent with this standard. Clinical social workers should assist in obtaining privileged communications legislation in all states.

4. Accountability

4.1 Clinical social workers' professional activity shall be guided by the principle of "promoting human well-being".

Interpretation.—Clinical social workers should provide service to consumers in a manner that is effective, efficient, and economical. Clinical social workers are responsible for making their services readily accessible to consumers in a manner that facilitates the consumer's freedom of choice when selecting a public provider. To accomplish this the public should be educated concerning the nature of clinical social work services, fees, the setting, their availability and the means of securing them. Clinical social workers must be aware of their accountability to the consumer of services, the sanctioners of clinical social work services and to the general public. The emphasis should be on the conservation of human, material, and financial resources.

4.2 Clinical Social Work is an autonomous profession.

Interpretation.—Clinical social workers shall be aware of the implications of their activities for the profession as a whole. They shall seek to eliminate discriminatory practices instituted for self-serving purposes which are not in the interest of the consumer. They shall be aware of the responsibilities for the development of the profession, and assist where possible in the training and career development of students and other providers. They shall facilitate the development of and participate in professional standards review mechanisms on the national/state/local level.

Clinical social workers shall seek to work with other professionals in a cooperative manner for the benefit of the consumer and the benefit of the general public. Clinical social workers associated with multidiscipline settings shall support the principle that professionals shall have equal rights to vote, hold office, administer service programs in their respective areas of competence, and share the privileges and responsibilities for full membership in the human service facility. The clinical social worker is committed to the basic values of the profession including the inherent worth, integrity and dignity of the individual.

4.3 There shall be periodic, systematical and objective evaluation of clinical social work services.

Interpretation.—Support for the principle of the autonomy of clinical social work as a profession is based on the premise that as a member of an autonomous profession, the clinical social worker rejects limitations upon his freedom of thought and action other than those imposed by his/her moral, legal and social responsibilities. Clinical social work is always ready to provide appropriate assistance to any responsible professional peer who becomes subjected to unreasonable limitations on his opportunity to function as a practitioner, teacher, researcher, administrator, or consultant.

The insistence upon professional autonomy of the clinical social worker will be upheld through affirmative actions in the courts, with government agencies, insurance carries and other professional organizations in support of the right of the clinical social worker to pursue those functions for which he/she is trained and qualified to perform.

4.4 Clinical Social Workers are accountable for all aspects of the services they provide and shall be responsive to those concerned with these services.

Interpretation.—In recognizing their responsibilities to sanctioners, other professional organizations, consumers, government organizations, insurance carriers, and consistent with the vital interests of such groups, clinical social workers shall make available information about, and opportunity to participate in decisions concerning such issues as initiation, modification, termination, and evaluation of clinical social work services.

These Standards shall be available to these groups. Information shall be available to prospective consumers concerning the nature of clinical social work procedures, the nature and extent of services provided, financial costs, and peer review mechanisms.

Clinical social workers shall inform consumers of services of fee policies and provide assistance in enabling the consumer to obtain reimbursement for fee payments. Clinical social workers who accept third party reimbursement shall be acquainted with the appropriate statutes and regulation, instruct the consumer on proper claim submission procedures, and shall ensure confidentiality of claims information.

5. *Environment*

5.1 The providers of clinical social work services shall promote the development of a physical and social environment that facilitates the delivery of effective clinical services.

Interpretation.—It is the obligation and commitment of social work practitioners to give attention to the comfort and privacy of providers and consumers. It is also the practitioner's responsibility to structure the process of the delivery of clinical social work services in such a manner as to promote an orderly and comfortable social environment for the consumer working with local social welfare and health agencies and organizations. The clinical social worker should strive to communicate an atmosphere of professionalism and competence in which the consumer of services can feel a sense of personal safety and acceptance. The practitioner should foster the positive self-image of consumers and to preserve their human dignity. The clinical social worker must recognize that he/she alone is accountable for the consequences and effects of services provided patients and other consumers of services, whether as therapist, teacher, consultant or researcher. The responsibility cannot be shared, delegated, or reduced.

6. *Specific standards for clinical practice*

Such standards are in the process of being developed by local clinical social work peer review and standards committees.

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APPENDIX

NATIONAL FEDERATION OF SOCIETIES FOR CLINICAL SOCIAL WORK: ETHICAL STANDARDS OF CLINICAL SOCIAL WORKERS

PRINCIPLE 1. RESPONSIBILITY

The clinical social worker is committed to the basic values of the social work profession. Namely: the inherent worth, integrity and dignity of the individual; the right to self-determination; a firm belief in equal opportunity for all, limited only by an individual's innate capacity and social responsibilities towards oneself, family and society . . .

The clinical social worker functions with the awareness of the dynamic interplay of personal, biological and psychological elements with the socio-economic forces in the environment in which human beings live and endeavors to assist his client—individual, group or community—to reach the highest possible degree of social. mental and physical well being.

As the clinical social worker recognizes the multiplicity of causation of social and emotional problems he is concerned both with giving personal help to clients and in social action, with measures which aim toward a change of the social conditions that cause or contribute to human suffering and maladjustment.

The clinical social worker carries responsibility to maintain and improve social work service; constantly to examine, use and increase the knowledge upon which practice and social policy are based and to develop further the philosophy and skills of the profession.

PRINCIPLE 2. COMPETENCE

In order to maintain or enhance his professional competence, the Clinical Social Worker will avail himself of educational opportunities and, when indicated, will seek consultation service from colleagues and/or other suitable professionals.

PRINCIPLE 3. MORAL AND LEGAL STANDARDS

The clinical social worker in the practice of his profession shows sensible regard for the social codes and moral expectations of the community in which he works. recognizing that violations of accepted moral and legal standards on his part may involve his clients, students or colleagues in damaging personal conflicts and impugn his own name and the reputation of his profession.

PRINCIPLE 4. MISREPRESENTATION

The clinical social worker shall not misrepresent his professional qualifications and associations.

a. Professional qualifications are accurately represented, as are associations with agencies, professional groups or individuals. The clinical social worker shall have the responsibility to correct those misrepresentations of others.

b. The clinical social worker shall not misrepresent any agency or organization by presenting it as having attributes it does not possess.

c. The clinical social worker shall not permit his name to be used in connection with any advertisements.

PRINCIPLE 5. PUBLIC STATEMENTS

When the clinical social worker is in a position of providing the public with information (directly or indirectly), he shall do so judiciously, fairly, accurately and without misrepresentation.

a. The clinical social worker shall not permit his name to be used in connection with any advertising for commercial reasons.

b. The clinical social worker who chooses to publicly endorse political candidates or issues shall do so as a private individual and not as a representative of the Society for Clinical Social Work.

c. The clinical social worker shall make no public statements about any patients or clients, unless in an educative fashion, speaking with respect to the individual, group or organization's confidentiality.

PRINCIPLE 6. CONFIDENTIALITY

Information about any individual, group or community shall be considered privileged communication and shall be respected with regard to confidentiality. This is to be considered one of the most basic of responsibilities of the clinical social worker.

a. Confidential information revealed to the clinical social worker shall only be revealed to the appropriate professional people when there is an immediate danger to an individual or society in the judgment of the clinical social worker. That such information will be released will be shared with the individual by the clinical social worker.

b. When confidential information is to be used for professional educative purposes every effort shall be made to conceal the true identity of the individuals discussed.

c. Confidential material shall be released to other professional people when there is a signed authorization from the individual.

PRINCIPLE 7. CLIENT WELFARE

The clinical social worker respects the integrity of the person or group with whom he is working and is protective of their welfare.

a. When the clinical worker finds himself in situations in which a conflict of interest may arise among various parties such as management and labor, or between client and employer, the clinical social worker defines for himself the nature and discretion of his responsibilities and loyalties and informs all parties concerned of these commitments.

b. When there is a conflict among professional workers the clinical social worker's primary concern is with the welfare of any client involved and only secondarily with the interests of his own professional group.

c. The clinical social worker should attempt to terminate a clinical or consulting relationship when it is reasonably clear to the clinical social worker that his client is not benefitting from it.

d. The clinical social worker who receives personal information from an individual in the course of an interview makes certain that the responsible party is fully aware of the purposes of the interview and the ways in which the information may be used.

e. In cases involving a referral the clinical social worker assumes full responsibility of the client until such time that it is assumed by the professional to whom the client is referred or until the relationship between the client and the clinical social worker is terminated by mutual agreement. Where referral. consultation or other changes in the condition of treatment are indicated and the client refuses referral, the clinical social worker carefully evaluates the possible harm to the client, himself and to his profession that might ensue if the relationship continues.

f. When potentially disturbing matter is presented to students, the clinical social worker discusses it openly and objectively and makes all efforts to handle constructively any difficulties that might have taken place.

g. The clinical social worker must take care to insure an appropriate setting for clinical work to protect both the client and clinical social worker from actual or imputed harm, and the professional from censure.

PRINCIPLE 8. CLIENT RELATIONSHIP

The clinical social worker makes known to the prospective client the important aspects of the potential relationship that might affect the client's decision to enter into the relationship.

a. Some of the aspects of the relationship that are likely to affect the client's decision include recording of an interview, the use of interview material for training purposes and the observation of an interview by other persons.

b. In the event that a client is not competent to evaluate the situation such as a child or a psychotic individual, the person responsible for the client is made known the circumstances which may influence the relationship.

c. The clinical social worker normally does not involve himself in the treatment of members of his own family, intimate friends, close associates or others whose welfare might be jeopardized by such a dual relationship.

PRINCIPLE 9. IMPERSONAL SERVICES

Clinical social worker services such as diagnosis, treatment, or counseling are only provided in the context of a professional relationship and are not given by means of public lectures or demonstrations, newspaper or magazine articles, radio or television programs, mail or anything of a similar nature.

PRINCIPLE 10. ANNOUNCEMENT OF SERVICES

The clinical social worker adheres to professional rather than commercial standards in making known his availability for professional services.

a. A clinical social worker does not directly solicit clients for individual diagnosis or therapy.

b. Individual listings in telephone directories are limited to name, highest relevant degree, certification status, address, and telephone number. They may also include identification in a few words of the clinical social worker's major areas of practice. Agency listings are equally modest.

c. Announcements of individual private practice are limited to a simple statement of the name, highest relevant degree, certification or diplomate status, address, telephone number, office hours and a brief explanation of the types of services rendered. Announcements by agencies may list names of staff members with their qualifications. They conform in other particulars with the same standards as individual announcements, making certain that the true nature of the organization is apparent.

d. A clinical social worker or agency announcing non-clinical professional services may use brochures that are descriptive of services rendered but not evaluative. They may be sent to professional persons, schools, business firms, government agencies, and other similar organizations.

e. The use in a brochure of "testimonials from satisfied users" is unacceptable. The offer of a free trial of services is unacceptable if it operates to misrepresent in any way the nature of the efficacy of the services rendered by the clinical social worker.

f. The clinical social worker must not encourage (nor, within his power, even allow) a client to have exaggerated ideas as to the efficacy of services rendered. Claims made to clients about the efficacy of his services must not go beyond those which the clinical social worker would be willing to subject to professional scrutiny through publishing his results and his claims in a professional journal.

PRINCIPLE 11. INTERPROFESSIONAL RELATIONS

A clinical social worker acts with integrity in regard to colleagues in social work and in other professions.

a. A clinical social worker does not normally offer professional services to a person receiving counseling or therapeutic assistance from another professional worker except by agreement with the other worker or after the temination of the client's elationship with the other professional worker.

b. The welfare of clients and colleagues requires that social workers in joint practice or corporate activities make an orderly and explicit arrangement regarding the conditions of their association and its possible termination. Social workers who serve as employers of other social workers have an obligation to make similar appropriate arrangements.

c. The welfare of clients and colleagues requires that the clinical social worker conform to the spirit and intent, as well as the actual letter of the licensing requirements in regard to the private practice of clinical social work. The clinical social worker shall not participate in or encourage arrangements whereby lesser qualified social workers practice privately.

PRINCIPLE 12. REMUNERATION

Financial arrangements in private practice are in accord with professional standards that safeguard the best interest of the client and the profession.

a. In establishing rates for professional services, the clinical social worker considers carefully both the ability of the client to meet the financial burden and the charges made by other professional persons engaged in comparable work. He is willing to contribute a portion of his services to work for which he receives little or no financial return.

b. No commission or rebate or any other form of remuneration is given or received for referral of clients for professional services.

c. The clinical social worker in clinical or counseling practice does not use his relationships with clients to promote, for personal gain or the profit of an agency, commercial enterprises of any kind.

d. A clinical social worker does not accept a private fee or any other form of remuneration for professional work with a person who is entitled to his services through an institution or agency. The policies of an agency may make explicit provision for private work with its clients by members of its staff, and in such instances the client must be fully apprised of all policies affecting him.

PRINCIPLE 13. RESEARCH PRECAUTIONS

The clinical social worker assumes obligations for the welfare of clientele who willingly participate as research subjects.

a. Only when a problem is of scientific significance and it is not practicable to investigate it in any other way is the clinical social worker justified in exposing research subjects, whether children or adults, to physical or emotional stress as part of an investigation of a treatment modality.

b. The clinical social worker seriously considers the harmful aftereffects and avoids them, or removes them as soon as permitted by the design of the research.

c. Investigations of human subjects using experimental drugs should be conducted only with appropriate medical coverage in such settings as clinics, hospitals or research facilities maintaining safeguards for the subjects.

PRINCIPLE 14. PUBLICATION CREDIT

Credit is assigned to those who have contributed to a publication, in proportion to their contribution, and only to these.

a. Major contributions of a professional character, made by several persons to a common project, are recognized joint authorship. The experimenter or author who has made the principal contribution to a publication is identified as the first listed.

b. Minor contributions of a professional character, extensive clerical or similar nonprofessional assistance, and other minor contributions are acknowledged in footnotes or in an introductory statement.

c. Acknowledgment through specific citations is made for unpublished as well as published material that has directly influenced the research or writing.

d. A clinical social worker who compiles and edits for publication the contributions of others publishes the symposium or report under the title of the committee or symposium, with his own name appearing as chairman or editor among those of the other contributors or committee members.

PRINCIPLE 15. RESPONSIBILITY TOWARD ORGANIZATION

A clinical social worker respects the rights and reputation of the institute or organization with which he is associated.

a. Materials prepared by a clinical social worker as part of his regular work under specific direction of his organization are the property of that organization.

Such materials are released for use or publication by a clinical social worker in accordance with policies of authorization, assignment of credit, and related matters which have been established by his organization.

b. Other material resulting incidentally from activity supported by any agency, and for which the clinical social worker rightly assumes individual responsibility, is published with disclaimer for any responsibility on the part of the supporting agency.

Mr. ROSTENKOWSKI. Mr. Beauregard?

STATEMENT OF ROBERT M. BEAUREGARD

Mr. BEAUREGARD. Thank you.

Mr. Chairman and members of the subcommittee, it is a pleasure to appear before you in behalf of the agencies, individual practitioners, and State programs which make up the membership of the Alcohol and Drug Problems Association of North America. We value this opportunity to share our views and suggestions on the subject of national health insurance.

The willingness of the subcommittee to continue the debate on national health insurance is encouraging. There is a crucial need to examine what it is every citizen can expect to get and not get from the dollars, personnel, and organizational approaches that are proposed. Our interest is in improving the quantity and quality of services for citizens affected by alcohol and other drug-taking problems.

There is a growing body of knowledge about these conditions and a growing awareness that they are treatable. In fact, citizens affected usually have an excellent prognosis when adequate services are available and provided. To this point, however, the health care system that is projected to spend $118.4 billion in 1975 commits very few dollars or personnel to providing these services.

The Nation's investment in health care and most of the expectations concerning national health insurance are at the core fixed on the provision of medical care. The system is mainly responsive to manifest illness and accident problems. There is little real investment in services that go beyond the hospital and into the homes and neighborhoods where citizens must make so many daily decisions concerning their well-being and ability to function.

Mainly, the national health insurance debate has been centered on achieving a more systematic and efficient approach to the provision of medical care.

The elected official at National, State and local levels is under a great deal of pressure to do something about improving the availability of this medical care product. You are brokers for citizens who should have available a more encompassing health care program. Your decisions, quite obviously, can have a profound impact upon the quality of life in America.

Some of the basis for this more limited medical care approach is due to the public's view of health care. Many believe there is a "pill" or a "cure" for everything. The greater portion of medical care intervention is dependent upon the manifest recognition by patient and doctor that he is sick and often so sick that he cannot continue to carry out job and family responsibilities. Furthermore, much of the focus of modern medicine has been on the ability to rescue lives no matter how bad the situation has become.

This drama holds the greatest status in medicine for the public and professionals. It also is the most expensive kind of medicine, and I personally think we are finding that the public's notion that medicine can always cure our ills with a pill or a diet or an operation may be contributing to greater risk-taking, neglect of early warning signs, and therefore even greater costs. Thus, the greater portion of our investment in health care not only may not support early intervention, but may actually run counter to it. This is not only the most expensive kind of health care, in dollars, but in dysfunction for the individual and society.

Most care dollars are now going into medical care. Our concern is that national health insurance likely will reinforce that monopoly over the amount that society is willing to spend for care. As mentioned, an amount of $118.4 billion is projected for 1975 and we are alarmed that the increase has been rising so sharply.

In contrast, Congress and the administration put a $2.5 billion lid on social services because they were getting out of hand. Yet these are some of the followthrough services required to sustain the gains from medical care, and they represent service opportunities for the application of our knowledge of prevention. It seems to me that there is a considerable bias in our priorities.

It would be nice to think that national health insurance will provide for the broad range of community services needed to be responsive to citizens with alcohol and other drug-taking problems. That prospect is uncertain and we have some concern that national health insurance may result in the drain of more scarce service dollars away from home care, counseling services, work-related programs, and other forms of services that have proven so successful with people with alcohol and drug abuse problems, and so far less expensive than hospital and other medical care-related institutional services. Given these needs, support for national health insurance is a mixed blessing.

ALCOHOL AND DRUG PROBLEMS

Alcohol and other drug-taking problems have a profound impact on the citizens and economy of this country.[1] There are 9 million people with serious alcohol-drinking problems. Each year there are more than 25,000 alcohol-related traffic fatalities, 15,000 alcohol-related homicides and suicides, 20,000 deaths from alcohol-related diseases, 20,000 fatalities due to alcohol-related accidents, and 2 million arrests each year for simple drunkenness.

One out of every ten members of the Nation's work force is an alcoholic or has a serious alcohol drinking problem. The result is an estimated $25 billion a year drain on our economy. Yet, we have data indicating that fewer than 10 percent of the citizens who have alcohol drinking problems are receiving the treatment they need. This is all the more tragic as we have learned that when adequate treatment is provided, the prognosis is very good.

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[1] The source for figures on alcohol and drugs was the Honorable James D. Isbister, Administrator, Alcohol, Drug Abuse, and Mental Health Administration, in his presentation on September 15, 1975, to the 26th Annual Meeting of the Alcohol and Drug Problems Association of North America, Chicago, Illinois.

Recent estimates of the national drug problem vary, but to cite a few, the 1974 Greenwood Estimates of the Drug Enforcement Administration indicate as many as 725,000 active narcotics users. In addition, the HEW estimates that there are 12.5 million marihuana users, 6.8 million persons involved in the nonmedical use of stimulants, primarily amphetamines, and 5.3 million in the nonmedical use of sedatives.

The drug problem costs more than $10 billion to our economy and a great deal in human suffering. Again we have found that treatment is effective when it is made available.

SERVICES NEEDED

Treatment needs for citizens with alcohol and other drug-taking problems cut across all community health and social services. There are related medical problems like hepatitis, cirrhosis of the liver, hypertension, and heart disease, or medical care needs related to detoxification. Both inpatient and outpatient mental health services also may be needed.

Individual and family counseling, social services, legal aid, and vocational rehabilitation are among the crucial and important services that need to be available in a continuum of care that may or may not include hospitalization, but often could benefit from halfway or quarterway house or other in-community residential facilities. All are important treatment modalities to citizens with alcohol or other drug-taking problems, but health insurance coverage has often been restricted to hospital and medical care.

Coverage under national health insurance for this full range of services may not be possible. It is important to identify these services. This makes it possible for the subcommittee to consider the extent to which a particular comprehensive national health program is comprehensive for citizens with alcohol and drug problems, and for us to understand what it is we can and cannot expect from national health insurance.

HEALTH INSURANCE COVERAGE

Hallan in a 1972 study of health insurance coverage for alcoholism found a range of widely differing policy benefits while certain policy limitations as the place of care were quite similar. For example, care was often covered in a general hospital setting, but not in a specialized alcoholism facility or psychiatric hospital. Outright exclusion from policy benefits was not infrequent. Most notable was that insurance coverage for alcoholism did not resemble that for physical disease. The extent of coverage, however, did appear to be improving.

He identified a number of issues related to the problem of health insurance coverage. It was apparent that both public and private insurance carriers lagged behind expressed or implicit service needs. They do not take the initiative to underwrite costs of new or different forms of treatment.

Second, an emphasis on hospital care persists among the health insurance industry. Further, a majority of the policies examined limited alcoholism related care to a recognized hospital and not, as has been mentioned, to a specialized alcoholism facility or psychiatric hospital.

Another issue that persists was the tendency to support treatment of alcoholism provided it is diagnosed as something else. A frequent issue against underwriting alcoholism care was the cost of such treatment. Few studies existed and perhaps the basis for it was related to the uncertainty of the cost or the uncertainty that treatment would be of any value.

Recent developments have been more encouraging. In 1974 Blue Cross of Maryland expanded its group health coverage to include the rehabilitation of alcoholic persons at State-licensed nonhospital residential facilities and, during 1975, began to include coverage of outpatient care.

The Capitol Blue Cross Plan of Harrisburg, Pa., has instituted coverage for alcoholism treatment with no increase in premium to the subscriber. Alcoholism is now treated under "allowable general hospital days" instead of the more narrow and common category of "nervous and mental disorders."

A government program, the Civilian Health and Medical Program for the Uniformed Services (CHAMPUS) which covers military personnel and their dependents provides full coverage for alcoholism treatment. CHAMPUS recently released fiscal year 1974 information on costs and utilization, giving as the average number of hospital days per admission for patients with alcoholism problems as 4.8 days, at an average cost per admission of only $272.08.

The State of California recently implemented a health insurance benefit package for alcoholism treatment coverage for all State employees and their dependents. This involved coverage for more than 300,000 individuals. The package covers alcoholism as a primary diagnosis and includes 6 days of detoxification, 21 days in a general hospital or specialized alcoholism treatment center, 30 days in a recovery home or other residential facility, and 45 outpatient visits.

STANDARDS

One of the difficulties in obtaining health insurance coverage has been the lack of or poorly defined standards for alcohol and drug problem treatment, facilities, and personnel. Federal law now requires the States to establish such standards. Some like Minnesota and Kansas have done so and other States are well on their way.

The Joint Commission on Accreditation of Hospitals (JCAH) has established national standards for accreditation of alcoholism and drug programs. Surveys began for alcoholism programs in September of 1974 and drug programs recently got underway.

Counselor certification is another issue as about two-thirds of the care provided is done by nondegreed professional treatment staff. Here, too, a number of States have governmental or nongovernmental certification programs. Efforts to establish a national certifying body are underway.

Most of the increases in coverage and the clarification of alcohol and drug problems as distinct from mental illness or other conditions by carriers are a direct result of these efforts to establish standards. Again, as with the description of the range of services needed, these standards will help to define the extent to which National Health Insurance covers or does not cover the care needs of citizens with alcohol and other drug-taking problems.

COVERAGE UNDER PROPOSED BILLS

On the bills proposed in the 94th Congress only two provide explicit coverage for alcohol and drug problem services. They differ in approach and coverage. Our own review was limited to services for alcoholism, but we assume drug addiction is the same.

The broadest coverage is proposed under the Health Security Act of 1975 (H.R. 21), introduced by Representative James C. Corman and Senator Edward M. Kennedy:

1. Inpatient benefits—unlimited. Treated as any other physical illness. No deductibles or coinsurance.
2. Physicians' services—unlimited, as in the case of all other physical illnesses covered by the bill.
3. Outpatient benefits—a person diagnosed as alcoholic would be able to receive services not only from hospitals, mental health centers and other providers who offer alcoholism services, but would also be treated as an outpatient in a free standing ambulatory center.

Somewhat more limited was the National Health Care Services Reorganization and Financing Act (H.R. 1), introduced by Representative Al Ullman:

1. Inpatient benefits—90 days of inpatient hospital care received in any benefit period; copayment $5 per day.
2. Physicians' services—limited to first 10 visits to physicians and services of other qualified health professionals and allied health personnel per coverage year. Copayment $2 for each physician visit.
3. Outpatient services—outpatient institutional care programs for physically disabled, mentally ill and alcoholic persons would include day care or part-time services. A person diagnosed as alcoholic would be entitled to 3 days of outpatient care in place of each day of inpatient care allowable during a benefit period.

The other bills rely on conventional or standard forms of hospital and professional care. They tend to ignore the range of services needed outside the medical care setting and thus would be limited. The lack of coverage for followup services would likely abort any treatment gain initiated in the hospital for alcohol and drug problems.

Unlimited coverage of inpatient benefits and physician services may contribute to higher cost for services. There is some limited data in the California experience to suggest that citizens with alcoholism problems and providers favor hospital care, if there is no clear incentive to avoid it. A great deal of care can and should be provided in nonhospital settings.

Much also can be done on a nonresidential basis. Perhaps there should be limits on institutional care and, in addition, incentives like that proposed by Representative Ullman, entitling a person to 3 days of outpatient care in place of each day of inpatient care.

CONCLUSIONS

Citizens with alcohol or other drug-taking problems may or may not find they are provided coverage under National Health Insurance for the full range of services they need. We hope they do. These conditions are treatable and the treatment modalities of choice are both less expensive than hospital care and reinforce a broader health care context for services.

This country has invested an increasing proportion of the Nation's care dollars in medical care. The commitment relates to demand, but it is a demand that likely was stimulated by this Nation's increased investment in biomedical research in the 1950's. But our knowledge of health care outstrips delivery and much of what we know is not made available through acute medical care services.

Citizens with alcohol and other drug-taking problems can be helped to function effectively. Hopefully, the Nation's courtship with National Health Insurance will include coverage for these conditions as well.

Mr. Rostenkowski. Mr. Gorman.

STATEMENT OF MIKE GORMAN

Mr. Gorman. I first testified on health insurance in 1950 in working for a gentleman named Harry S Truman. I was then executive director of the President's Commission on the Health Needs of the Nation, and you know where we got then. If we had gotten anywhere then, we would not be here now. We had a few people who were against us and I won't mention the organizations specifically, and I won't even call them lobbies. But we were bombed out.

Now I am going to highlight the major points in my very short statement. As to the reason for our interest in alcoholism and its coverage and the reluctance of carriers to do it up to now, the best testimony I have seen so far was in the National Journal, a very good publication, the latest issue, November issue, and it is the memorandum from the chairman of one committee to the chairman of another committee, and both of the Congressmen's names begin with "R." I won't identify them, but I will quote the one who is the chairman of this hearing this morning.

The chairman says:

> My conviction is that this Nation urgently needs a national health care policy which addresses the issues of health care, the preservation and maintenance of health, as well as its restoration much more broadly than do current national health insurance proposals, almost all of which are aimed exclusively at the financing and delivery of services to ill and injured people.
>
> We need a health care policy that will also stimulate and give direction to a massive effort aimed at the prevention of preventable diseases and accidents.

Now I think that just puts it beautifully. That statement is from a gentleman named Congressman Rostenkowski of Chicago to a Mr. Rogers of Florida, I believe.

I would summarize, just going through this briefly, our feelings on costs, because you are going to have to deal with costs and financing as probably your major problem.

"It costs too much." "We can't do it." "The economy can't afford it." "We have energy problems"—got this, got that. We are today hospitalizing too many of the alcoholics we are treating. They don't need to be hospitalized. There is even doubt that they have to be detoxified in a hospital setting.

It is an old throwback to my days in State mental hospitals when—not as a patient, but as a newspaper reporter—everybody said send them off to the State mental health hospitals. We have cut that down, the population of the State mental hospitals, by 330,000 since we got some mental health centers and drug programs going.

That was the policy of this Government of 200 years for the mentally ill and it was costing the States like crazy. They had these people in there for a lifetime, 40 or 50 years some of these people were in. One I found in Manteno, which is a State hospital in Illinois, 73 years in that hospital.

Now what was the cost? When the administrator was saying we do it all for $4.11 a day, I said, "You sure do a fine job, buddy boy. What kind of treatment do you give a person in a warehouse-like Manteno or Kankakee or any of the hospitals?"

I remember the support we got from the Governors in turning this around. We went to a few national Governors' conferences, about 15, and a lot of regional Governors' conferences, and it was really under Otto Kerner, in Illinois, that the thing just turned around completely. He said, "OK, if this new mental health center concept has any validity, let's try it. The other system isn't working."

Each year the State mental hospitals come in and say, we need more money, we need more buildings, because nobody was getting out. You keep building, building, building, and put a plaque on it, built during the administration of Joe Smoo. That is the only thing we were doing.

In the hearings that were held last year before this committee, before the full committee, James S. Kemper of Chicago, president of Kemper Insurance Cos., testified on behalf of the National Council on Alcoholism before the full House Ways and Means Committee, which was then considering National Health Insurance.

Mr. Kemper is on the National Council on Alcoholism Advisory Group on Health Insurance, which was formed in 1971 to study in depth, in cooperation with the National Institute of Alcohol Abuse and Alcoholism, the problem of inadequate insurance coverage on alcoholism.

We had very little then and we have very little now. In his formal statement Mr. Kemper noted, "The NCA was formed in 1944 in a public atmosphere of almost total ignorance, prejudice and fear toward the alcoholic." That is an understatement.

"At that time the alcoholic was considered a hopeless proposition, wholly to blame for his own condition." All he had to do was put the bottle down. That has changed completely.

Medicine has changed its attitude completely toward the alcoholic. There was a time when doctors wouldn't treat the alcoholic. He was dirty, messy. He couldn't be cured. That is just the way they treated the mentally ill people. You didn't treat people that you couldn't cure.

It has been a long and arduous battle to remove the stigma attached to alcoholism in the public mind. It still goes on. I kid you not. This is paralleled to a considerable extent in the equally negative attitude of the medical profession toward alcoholism, although that also is changing tremendously under the weight of scientific evidence.

Our first breakthrough came in 1956 when the American Medical Association officially categorized alcoholism as a medical disease. That is going to be the thrust of these few remarks I have to say.

This is a disease. This is not just something related to will power. This is not something you can't define.

We have criteria for the diagnosis of alcoholism. We show physicians how they can detect the early signs of alcoholism. But what we have been treating up to now, when we have been treating it and not throwing these poor fellows off into State mental hospitals or jails, we have not ever gotten at the early stages of alcoholism and they are very clearly outlined and defined for the physician in the scientific criteria published and widely disseminated by the NCA.

This has been accepted and published by the Journal of the American Medical Association, not known as a radical organization, and by many other publications. Since 1956 many other professional organizations, the World Health Organization, the American College of Physicians, the American Psychiatric Association, and others too numerous to list here have adopted the AMA position.

This is a physical disease and should be classified as such and not discriminated against by limitations as to time, outpatient services, residential treatment centers, and all the inhibitions that prevent the doctor from treating it early. When it gets to the terminal state, he is forced to send the patient to the hospital where he frequently dies.

Now I think these and other developments, and these developments I am talking about are just developments over the last 5 or 6 years, that is how recent the attitude toward alcoholism has been. I think Mr. Beauregard would agree. It has been just that dramatic a change. They have led to a dramatic change in the public attitude toward the alcoholic.

Polls have been taken on this. Before 1970 the general public would not admit that alcoholism was a disease. They said, "Oh, you can stop it. It is something where you use a little willpower." They didn't realize what a powerful addictive drug Ethanol was and what it did to you.

But in 1974 the Lou Harris Survey reported that 73 percent of the American people thought that full coverage of alcoholism should be included in any National Health Insurance legislation. That is what we are talking about today, I think. Seventy-four percent, what a switch. Ten percent were not sure and 17 percent felt it should not be included.

Now a public change in attitude is one thing. It is very important and it is very important to you Members of the Congress. But the translation of this into actual programs for the alcoholic is another. According to a recent study by the Department of Health, Education, and Welfare, alcoholism now ranks only behind heart disease and cancer as a national health problem.

Mr. Beauregard went into statistics and they are still horrifying as to the number of arrests and homicides and so forth and so on. Fifty percent of homicides are alcohol-related. Either one or both of the people involved in this homicide were boozed up or tanked up. That to me is a staggering figure.

No other chemical agent can make that claim. It is a horrible claim to make, but no other agent can make that claim.

Now a few of the States are beginning to recognize this gap between public acceptance of alcoholism as a disease—and I keep saying it is a disease—and consequent insurance coverage of it. I may be wrong in this as the director of Public Policy Office of the National Council on Alcoholism, Mr. Chairman, in insisting that there be no 30 days for this and 15 days for that and 10 days for this jazz, that I used to do in the mental health days.

If it is a disease, it is covered like any other physical illness. We don't discriminate in this way for cancer or heart disease. We don't say you are covered this many days for this and that many days for that and if it is raining on Tuesday, you are not covered. We don't do that.

So I say we are talking about a very serious disease.

Over the past 2 or 3 years 12 States have required the health insurance carriers to include alcoholism in group insurance policies. That leaves out millions of individuals, but again it is a tremendous first step to mandate this coverage.

Now in all but two of these States this is restricted to inpatient treatment in general hospitals or other outpatient medical centers. Mr. Beauregard went into the Blue Cross experience. Blue Cross is becoming tremendously progressive in this area. They recognize the saving they can get if instead of keeping him in a $150 bed, they can treat this alcoholic for $45 to $50 a day, that this is an obvious saving and it is a more effective way of doing it.

I have been in some of the alcoholism units in this country in general hospitals. They are stuck off in the corner. They have the same old stigma. We have had this and, of course, I have said this for 25 years and bored the Ways and Means Committee and other committees about it. We have a hangup in this country since he advent of health insurance 40 years ago, that is, the health insurance carriers and Blue Cross and Blue Shield, which came in in the 1930's, that in order to be covered for an illness you have to be horizontal. You have to be lying down.

If you get up and move, you will give the administrator of the hospital a heart attack, all the nurses will start screaming. You have to lie down in an expensive $200 bed and then the insurance company says, "Oh, yes, we can cover you. We can take care of you."

The most effective treatment, and this is agreed upon by practically everybody, is for the alcoholic, after he is detoxified—and in many cases he doesn't have to have medical detoxification—is in the outpatient facility, the outpatient residential treatment center, group therapy and other modalities which can be covered very simply and actuarily.

Since 1971 Dr. Jerome B. Hallan, director of the Human Ecology Institute in North Carolina—that is an awful name, but it is a nice State—has been doing a series of studies of the coverage of alcoholism under the auspices of the National Institute on Alcohol Abuse and Alcoholism and the National Council on Alcoholism, our organization.

This scientist, I think, is the real pro in the business today. He is probably the most knowledgeable authority in the country on this subject. In his latest study, completed in April of 1975, Hallan is sharply critical of the insurance industry for its continued emphasis upon covering the expensive hospital bed for the alcoholic while ignoring other and much less costly treatment modalities.

I want to quote one observation from Hallan that really nails the point down, Mr. Chairman.

> Public insurers lag behind expressed or implicit service needs: The insurance industry emphasizes hospital care as a treatment area for alcoholism in spite of other less expensive alternatives; the insurance industry frequently applies sanctions against claims for alcoholism treatments per se; yet it appears to condone the use of pseudo-diagnoses which serve as a cover for alcoholism treatment and * * * in general health insurance carriers only rarely provide any reimbursement for outpatient services.

In other words, even to get into a hospital as an alcoholic, you know that the doctor in order to send you to a hospital, he doesn't put you down as an alcoholic. So you have lower back pain, you have gastritis, you have respiratory disease. You have a respectable disease, not alcoholism.

Any doctor will admit this and any professional organization will admit this.

The attitude of the health insurance industry is changing rapidly. At a panel of insurance company representatives on May 2, 1975, at the National Alcoholism Forum of the National Council on Alcoholism, Dr. James D. Westbay, associate medical director of the Metropolitan Life Insurance Co., not a small company, summed up the attitude of the health insurance executives and medical directors when he stated forthrightly, and this is the nub of my testimony: "Treatment of alcoholism belongs in every health insurance contract written," period. That is Dr. Westbay, that is not from me.

He is pretty high up in both the health insurance area and in the alcoholism area. Dr. Westbay challenged companies to demand that alcoholism be covered in their employee insurance plans. As he put it, "They should stop hemming and hawing about what is wrong with their employees when they are sick and admit the truth—alcoholism is a disease," and a very insidious disease.

There is a growing consensus among experts in the field that only a limited number of alcoholics have to be hospitalized in expensive hospital beds. I think that is where we get at the costs, because we are now up to fantastic annual health costs. It is estimated that total health care costs will be $118 million this year alone. I have been familiar with this since the Truman days. It makes it almost prohibitive, but we think that the only answer is early detection, prevention, and community alternatives.

This has been done by the mental health people with the network of mental health centers and they have saved this country money and have put in neighborhood mental health centers so these people don't have to be put off in the State "warehouses." That is what I called the State mental hospitals. That is what I called them in the '40's and '50's and I got shafted by many governors. They were both Republicans and Democrats, but that is all right, I figured I got a bipartisan shafting.

I checked out and found that the average mental patient in the United States as late as 1955 in a State mental hospital—and there were then about 550,000 in them—he received total contact with any physician or other treatment personnel 8 minutes a month. That is 8 minutes a month.

James Ray, the project administrator of the Labor-Management task force of the National Council and formerly with Employees Insurance of Wausau, which is in Wisconsin, told the Health Insurance Association of America, which is the largest group of private health insurance carriers, recently that "Present contracts for the most part generally direct alcoholism treatment toward the highest unit of cost, namely, inpatient care under the licensed general hospital category."

That is the kind of thing we are fighting. We want it covered. We want it covered fully without discrimination, but we want it covered in the most reasonable way it can be covered and in the most efficient way it can be covered, and that is not the general hospital.

Subsequently Mr. Ray criticized these companies, various companies that were for paying out large daily per diems when the alcoholics could be getting better care at $45 a day in some of the excellent non-hospital settings. This is absolutely true.

I have seen some of these residential treatment centers which use all kinds of treatments and rehabilitation and they have ground these people can walk on and they have group therapy sessions and every kind of treatment. Whereas if you are in an alcoholism unit in most general hospitals, you are in the dirtiest part of the hospital, you are closed off, some have screens and bars over them, nobody goes into them. And when you ask where the alcoholism unit is, peopls say, "What do you want to go there for?"

That is not true of all general hospitals, but it is still true of many. Yet that is where the doctor who does not know enough about it puts them—and we are beginning to educate them. Between George Meany and James Rothe, who is the former chairman of General Motors, which is a small company in this country—he is still a director and I guess he has some stockholdings in it—they have been doing a tremendous job of educating millions of workers and scores of doctors in the plants and in management and in corporations that the hospital is not the total answer. It is only a minor part of the answer.

What the foreman on the assemblyline has got to do and what the shop steward, who represents the union, has got to do is to detect the problem early enough. Joe misses Monday. He has a high accident rate. This has been done by the UAW in Detroit and elsewhere.

I have mounds of studies showing that it is so easy to detect the Monday morning absentee, the guy with the accidents, the guy whose job performance is slipping, and so forth. But they don't do this now in most industries in this country.

They just say, "I don't know; Joe, he is not good on Mondays but he comes in." Sure he comes in. He is all boozed up. He has had a big weekend, and he also has a bottle of booze in the john. They say he does his job, we cover up for him.

That attitude is changing very rapidly.

To go into the specific bills, and I can't go into them in detail, there are so many bills that have been introduced we can't follow them all in detail. We only find two so far that really attempt to realize what we are tring to do, Mr. Chairman. The best one is H.R. 21 and also S. 3, in our opinion, the Health Security Act by Mr. Corman of this committee and Mr. Kennedy, et al., in the Senate. Of course, it has the most sponsors. I should not say "of course," but it does have the most sponsors at the present time. We are not saying it is perfection, but from the point of view of alcoholism the benefits of the Health Security Act are very simple.

The inpatient benefits, unlimited, treated as any other physical illness, no deductibles or coinsurance. The alcoholic only has 5 days in the hospital on the average now. The guy with a respiratory illness stays 8 days.

There are all kinds of stigmas that he is going to have all the rest of his life. As soon as he is detoxified, he is discharged. But the Kennedy bill covers full inpatient benefits, physician services unlimited. You may say "again."

Well, why do you say "unlimited?" Why don't you say a certain number of visits? We say it for this reason. We don't impose it for any other physical illness. We don't limit and say if you have cancer or heart disease, you are limited to so many visits. The alcoholic no more wants to go to the doctor than I want to go to my dentist.

So we say unrestricted benefits will encourage him to seek treatment at an early stage. But if this committee in its wisdom decides there are limitations to be imposed, and actuarily it proves out it is too expensive—we don't think it will be and our data are all to the contrary—but if we are limited, we want all other physical diseases limited in the same way.

On the outpatient benefits which Mr. Beauregard touched on very well, the person diagnosed as an alcoholic is not only to receive services from mental health centers, which are very important for this, because they are in the community—they are in the neighborhood, they are around the corner—but he also may be treated as an outpatient in a free-standing ambulatory setting.

That means a halfway house and other facilities. It means anything that is qualified, that is accredited, and we are moving very rapidly with the accreditation of nonhospital facilities of all kinds for alcoholics. It has been the most rapid development of 1975.

I have never seen anything like it in 25 years of deep concern health insurance.

The other bill that touches upon it is, of course, H.R. 1 by Mr. Ullman, the chairman of the full committee. However, Hallan and others who have studied the Ullman bill very carefully are critical of the limitation of physician services. They could be wrong, they could be right. But they are critical—they did a very long study of it—and also of the limitation of services of other health professionals. You don't need a high-powered doctor, a surgeon, to treat an alcoholic. Sometimes a recovered alcoholic is the best treatment for the alcoholic.

Look at the growth of Alcoholics Anonymous. None of them are doctors, yet it is simply fantastic that millions of people have attained sobriety in 40 years through Alcoholics Anonymous and we offer that as a powerful argument, too.

Now the administration has not submitted a bill and I cannot comment upon it. It submitted a bill in 1974, the Comprehensive Health Insurance Plan, CHIP, and it is now working on a new bill which it will submit in 1976.

In a speech to the Alcohol and Drug Problems Association in Chicago in September—everything happens in Chicago—James D. Isbister, the administrator of the Alcohol, Drug Abuse and Mental Health Administration—they are all loosely combined now under one reorganization—declared that the exclusion of alcoholism, drug abuse, and mental health from any National Health Insurance program would be both bad medicine and bad economics. Amen.

The most important fact to lead to their inclusion, he said, has been the realization that mental illness, alcoholism, and drug abuse are both treatable and curable conditions. They are both very treatable and very curable. However, it is the contention of the National Council on Alcoholism, and it is also the contention of the AFL–CIO, the United Auto Workers, of the Teamsters, United Mine Workers, General Motors, Hughes Aircraft, Eastman-Kodak—I could mention them all.

give you all kinds of commercials for them because they are trying to obtain specific coverage for alcoholism as a disease—that they are absolutely right.

I have been in on the drafting of a fair amount of legislation, some good, some bad. For example, several other National Health Insurance bills lump alcoholism and drug addiction under mental illness, but without any specificity as to coverage. This was true of the administration's 1974 bill and it is true of legislation introduced this year again by Harley Staggers, chairman of the House Interstate and Commerce Committee, and by Dr. Tim Lee Carter, for whom I have the highest regard, of the Health Subcommittee of that full committee.

We have found in too many cases that when the alcoholic goes to be paid for his treatment, they say, "Oh, we cover mental illness. We don't cover alcoholism." Then you say to them, "It says mental illness including alcoholism." And you get into a real hassle. You have to make a very clear distinction about what you are getting at.

When you have 9 million alcoholics, why do you include them under an umbrella that is so ambiguous that any health insurer can get out from under it?

Beyond the fact that many experts contend that a high percentage of alcoholics have an addiction to one specific chemical, Ethanol, the manner in which the alcoholic is treated involves a whole set of wholly different treatment facilities, treatment personnel as so forth. These are backed by the position of the AFL–CIO. I have referred to it. I have sent up to the desk the latest union-management approach to specific coverage of alcoholism.

One of the strongest statements on it is by George Meany, of course, who is co-chairman of the Labor and Management Committee of the National Council on Alcoholism, when he said, "Alcoholics need help, medical care, counseling, insurance coverage"—bango—insurance coverage, and, finally, "integration into our society."

This is the first book they put out two years ago and they have distributed 200,000 copies. So we are making tremendous progress.

American labor, therefore, is deeply interested in the problem of insurance coverage of alcoholism as a disease.

The rest of the statement, I think, is pretty self-explanatory. I would pay a tribute, and I pay this honestly, Mr. Rostenkowski, to your new mayor in Chicago, Richard Daley, who 19 years ago established an alcoholism treatment center just for alcoholics, and they are treated there and most efficiently.

Chicago called a spade a spade. It broke down the stigma against alcoholism by calling it an alcoholic treatment center, not any other kind of broad-brush approach.

We know your difficulties and the number of witnesses and the agonies. We are not taking any position at the present time in favoring any single bill. We want to base it upon certain principles, the principle of early prevention, early detection, that it is a disease, and that it should be covered as such and that we can save money.

Everybody comes up here and says, we will save you this amount of money, we will save you that amount of money. We know from our figures that we can, if you keep the alcoholic out of the hospital, where 95 percent of the time he does not belong in the first place.

So that is a tremendous saving because hospital beds in New York, the average now is only $222 a day. That is fantastic. I don't like to mention New York because it has other problems connected with default and everything else, but this is a fantastic waste of money. What the National Council on Alcoholism is proposing is something unique, a saving.

Under whatever National Health Insurance legislation is finally adopted, I don't know what is going to come out of this committee, this country cannot hope to put all its physically ill in hospital beds regardless of what it costs. A study by the NCA indicated that a vast majority of alcoholics can be handled less expensively in an outpatient center.

[The prepared statement follows:]

STATEMENT OF MIKE GORMAN, DIRECTOR, PUBLIC POLICY OFFICE, NATIONAL COUNCIL ON ALCOHOLISM

NATIONAL HEALTH INSURANCE MUST COVER THE DISEASE OF ALCOHOLISM

Mr. Chairman and members of the Committee, in June of 1974, James S. Kemper, Jr. of Chicago, President of Kemper Insurance Companies, testified on behalf of the National Council on Alcoholism before the full House Ways and Means Committee. then considering national health insurance legislation. Mr. Kemper is a member of the NCA advisory group on health insurance which was formed in 1971 to study in depth, in cooperation with the National Institute on Alcohol Abuse and Alcoholism, the problem of adequate insurance coverage of alcoholism.

In his formal statement. Mr. Kemper noted: "The NCA was founded in 1944 in a public atmosphere of almost total ignorance, prejudice and fear toward the alcoholic. At that time the alcoholic was considered a hopeless proposition, wholly to blame for his own condition."

It has been a long and arduous battle to remove the stigma associated with alcoholism in the public mind and, in many cases, in the equally negative attitude of the medical profession towards alcoholism. Our first breakthrough came in 1956, when the American Medical Association officially categorized alcoholism as a medical *disease* which should be classified in the same category with any other physical illness. Since that time many other professional organizations—the World Health Organization, the American College of Physicians, the American Psychiatric Association and others too numerous to list here—have adopted the AMA position. The *Annals of Internal Medicine*, the *American Journal of Psychiatry* and other distinguished medical publications have published the NCA-sponsored *Criteria for the Diagnosis of Alcoholism*.

These and other developments led to a dramatic change in the public attitude toward the alcoholic. In 1974, the Harris Survey reported that 73 percent of the American people thought *full coverage* of alcoholism should be included in any national health insurance legislation, 10 percent were not sure, and 17 percent felt that it should not be included.

A public change in attitude is one thing, but translation of this into actual programs for the alcoholic is another. According to a recent study by the Department of Health, Education, and Welfare, alcoholism now ranks behind only heart disease and cancer as a national health problem. In both 1972 and 1974, the Department released massive studies pointing out that there were now nine million alcoholics, that alcoholism was responsible for one-half of the area traffic fatalities on our highways, that in one-half of the murders in the country either the killer or the victim, or both, were found to have excessive levels of alcohol in their bloodstreams, and that an alcoholic's life span is shortened by ten to twelve years due to excessive drinking.

A few of the states are beginning to recognize this gap between public acceptance of alcoholism as a disease and consequent insurance coverage of it. Over the past two or three years, twelve states have required health insurance carriers to include alcoholism in *group* insurance policies, but in all but two of the states this is restricted to inpatient treatment in general hospitals or other inpatient residential centers.

Since 1971, Doctor Jerome B. Hallan, Director of the Human Ecology Institute in North Carolina, has been doing a series of studies of insurance coverage of alcoholism under the auspices of both the National Institute on Alcohol Abuse and Alcoholism and the NCA. He is probably the most knowledgeable authority in the country on this subject. In his latest study, completed in April, 1975, Hallan is sharply critical of the insurance industry for its continued emphasis upon covering the expensive hospital bed for the alcoholic while ignoring other, and much less costly, treatment modalities. To quote Doctor Hallan: "Public insurers lag behind expressed or implicit service needs; the insurance industry emphasizes hospital care as a treatment area for alcoholism in spite of other less expensive alternatives; the insurance industry frequently applies sanctions against claims for alcoholism treatment per se; yet it appears to condone the use of pseudo-diagnoses which serve as a cover for alcoholism treatment and . . . in general health insurance carriers only rarely provided any reimbursement for out-patient services."

However, the attitude of the health insurance industry is changing rather rapidly. At a panel of insurance company representatives on May 2, 1975 at the National Alcoholism Forum of the NCA, Doctor James G. Westbay, Associate Medical Director of the Metropolitan Life Insurance Company, summed up the attitude of the health insurance executives and medical directors when he stated forthrightly:

"Treatment of alcoholism belongs in every health insurance contract written."

Doctor Westbay challenged companies to demand that alcoholism be covered in their employee insurance plans. As he put it: "They should stop hemming and hawing about what is wrong with their employees when they are sick and admit the truth—alcoholism is a disease."

There is a growing consensus among experts in the field that only a limited number of alcoholics have to be hospitalized in expensive hospital beds. James Ray, Project Administrator of the Labor-Management Task Force of the NCA and formerly with Employers Insurance of Wausau, told the Health Insurance Association of America recently that "present contracts for the most part generally direct alcoholism treatment toward the highest unit of cost—namely, inpatient care under the licensed general hospital category." Subsequently Mr. Ray criticized these companies for "paying large daily per diems when the alcoholics could be getting better care at $45 per day in some of the excellent non-hospital settings."

In his continuing studies of national health insurance coverage of alcoholism, Doctor Hallan has reviewed most of the bills in detail. He comes to the conclusion that the Health Security Act (H.R. 21 and S. 3) is the only one of the major health insurance bills which provides adequate coverage for alcoholism. To quote from the Hallan 1975 study: "It is important to note that for the first time, alcoholism does not fall under mental illness. It is covered directly as a disease—as any other physical illness—and, unlike mental illness, is not singled out for limitation of both inpatient and outpatient benefits."

He lists the benefits of the Health Security Act as follows:

1. *Inpatient Benefits.*—Unlimited. Treated as any other physical illness. No deductibles or coinsurance.
2. *Physicians' Services.*—Unlimited; as in the case of all other physical illnesses covered by the bill.
3. *Outpatient Benefits.*—A person diagnosed as alcoholic would be able to receive services not only from hospitals, mental health centers and other providers who offer alcoholism services, but he also may now be treated as an outpatient in a free-standing ambulatory center.

While endorsing the major thrust of the Health Security Act, Doctor Hallan has some kind things to say about H.R. 1, the National Health Care Services Reorganization and Financing Act, introduced by Mr. Ullman, the distinguished Chairman of your full Committee. However, he and other experts in the field of insurance coverage of alcoholism are critical of limitation of physicians' services and services of other qualified health professionals and allied health personnel to ten visits, with a $2 co-payment for each physician visit.

He praises the inclusion of out-patient services to alcoholics in the Ullman bill. This benefit means that the alcoholic is entitled to three days of outpatient care in lieu of each day of inpatient care allowable during a benefit period. H.R. 1 requires a $2 co-payment per day for this service too.

While the Administration has not submitted a national health insurance bill this year, there is considerable evidence that it is reexamining its 1974 Comprehensive Health Insurance program to introduce technical improvements such as those we have stated. In a speech to the Alcohol and Drug Problems Association in Chicago in September, James D. Isbister, the Administrator of the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) declared that exclusion of alcoholism, drug abuse and mental health from any national health insurance program would be both "bad medicine and bad economics." The most important fact to lead to their inclusion, he said, has been "the realization that mental illness, alcoholism and drug abuse are both treatable and curable conditions."

However, it is the contention of the NCA that trying to write identical coverage for all three conditions is an actuarial impossibility. For example, several other national health insurance bills lump alcoholism and drug addiction under mental illness but without any specificity as to coverage. This was true of the Administration's 1974 bill, and it is true of legislation introduced this year by Mr. Staggers, Chairman of the House Interstate Commerce Committee, and by Doctor Tim Lee Carter of the Health Subcommittee of that full Committee.

Mr. Chairman, I speak as one who, over a period of two decades, battled at the state level for mental health insurance coverage. There were some successes and there were some failures and that battle is still going on.

We are concerned that alcoholism not be lumped under mental illness in any insurance coverage. Beyond the fact that many experts on alcohol in this country contend that a high percentage of alcoholics have an "addiction" to one specific drug—ethanol—the manner in which the alcoholic is treated involves a whole set of different facilities and treatment personnel. These experts are backed by the position of the AFL–CIO, which recently issued a statement pointing out that alcoholism is a specific disease entity, and that in its bargaining with management it would insist upon separate coverage for the disease of alcoholism. American labor is deeply interested in the problem of alcoholism, signified by the fact that Mr. George Meany, President of that organization, is also Chairman of the NCA's Labor-Management Committee. Labor and management programs which have the most success in treating the alcoholic are those which have steered clear of the so-called broad-brush or troubled-employee approach.

I might note that in your city of Chicago, Mayor Daly at the 1975 ADPA convention referred to previously was presented the Public Service Award of that organization for his role in developing and supporting Chicago's Alcoholic Treatment Center founded 19 years ago when practically no one in the country was talking about treating "dirty" alcoholics. Chicago called a spade a spade; it broke down the stigma against alcoholism by calling it an Alcoholic Treatment Center.

The National Council on Alcoholism is not at the present time taking the position of favoring any single bill. However, as a general principle it favors that legislation which will treat alcoholism as a disease to be treated as any other physical illness. If there were benefit limitations to be imposed upon alcoholism coverage, whether inpatient or out-patient, they should be no more restrictive than those for any other physical illness.

In conclusion, what the NCA is proposing is something rather unique—a saving—under whatever national health insurance legislation is finally adopted. This country cannot afford to put all of its physically ill into hospital beds which are skyrocketing in costs. A variety of studies and recent experience from business and industrial firms have indicated that a vast majority of alcoholics can be handled in less expensive out-patient settings.

Mr. Rostenkowski. Thank you, Mr. Gorman.

Would any of the panelists like to make a comment?

Mr. Duncan will inquire.

Mr. Duncan. I have no questions, Mr. Chairman. Thank you.

Mr. Rostenkowski. Mr. Burleson?

Mr. Burleson. I have no questions. Thank you.

Mr. Rostenkowski. I want to thank you, gentlemen, for appearing with us this morning.

Gentlemen, I would like to explain that at 11:45, the committee will rise to return at 1:15. We have a bill on the floor at 12 o'clock.

If you will introduce yourselves, identify the organizations that you represent, we will begin taking the testimony. I have already explained that we allow each of you the time allocated to make your presentation, and then go into an interchange if panelists so desire.

A PANEL ON SPECIFIC HEALTH PROBLEMS CONSISTING OF BRYAN B. HAMILTON, M.D., AMERICAN CONGRESS OF REHABILTATION MEDICINE; T. P. HIPKENS, DIRECTOR, ASSOCIATION OF REHABILITATION FACILITIES; MAYNARD I. SHAPIRO, M.D., NATIONAL EASTER SEAL SOCIETY; ELI GOLDENSOHN, M.D., EPILEPSY FOUNDATION OF AMERICA; GEORGE J. THEOBALD, JR., NATIONAL HEMOPHILIA FOUNDATION; AND CHARLES A. HOFFMAN, ISLIP TERRACE, N.Y.

Mr. Rostenkowski. Dr. Hamilton, you may proceed.

STATEMENT OF BRYAN HAMILTON, M.D.

Dr. Hamilton. I am Dr. Bryan Hamilton, director of research at the Rehabilitation Institute of Chicago. I am here today to testify on behalf of the American Congress of Rehabilitation Medicine, of which I am a member, and also on behalf of the American Academy of Physical Medicine and Rehabilitation; both have endorsed my statement and authorized me to speak for them.

The American Congress of Rehabilitation Medicine is a multi-disciplinary organization whose members represent all the professions that make up the rehabilitation teams which care for the Nation's disabled people. Closely related to the American Congress is the American Academy of Physical Medicine and Rehabilitation, composed of physicians who are board-certified members of the specialty of physical medicine and rehabilitation.

Mr. Chairman, as you know, the Rehabilitation Institute of Chicago is one of the Nation's largest comprehensive medical rehabilitation centers, and it is also one of the newest. It represents a commitment of $7 million in Federal money and $19 million from private citizens, corporations, and foundations of Chicago and the Midwest; a commitment to conserve our human resources, those disabled by injury, disease, or defect of birth, through the process of medical rehabilitation.

We will reiterate previous testimony before this committee (April 26, 1974) by indicating that the American Congress of Rehabilitation Medicine and the American Academy of Physical Medicine and Rehabilitation both support a Federal law which would require health insurance coverage of a uniform and broad nature for all Americans regardless of income.

The primary purpose of the testimony today, however, is to point out the necessity of including coverage of comprehensive rehabilitation services in a national health insurance program and further, to recommend that there be included a clear and realistic definition of what the rehabilitation services are.

Of particular concern is that appropriate and timely care be provided for "catastrophic illness." These are the illnesses which produce severe disablement for long periods of time with very disruptive consequences to the individual, the family, and to society which may be burdened with a dependent, nonproductive member as well as high costs for long-term care and income maintenance. We have come to recognize that the rehabilitation process, applied appropriately and early, results in less long-term disablement, higher levels of life functions, less family disruption, and importantly, less cost for care and income maintenance in the long run.

We would like to devote the remainder of this testimony to describing the magnitude of the need, what the rehabilitation process is and document the effectiveness of that process in restoring our human resources and the cost savings in doing so. Further, we would like to point out some of the consequences of inadequately defining rehabilitation services in a health insurance plan and, finally, indicate an appropriate definition of rehabilitation services for a national health insurance program.

WHO NEEDS REHABILITATION SERVICE?

Each year in the United States new injury and disease directly affect the lives of millions of people. The disability which results varies in type and extent. The National Safety Council indicates that in 1974, 380,000 people had permanent impairments resulting from accidents. Of the 10,000 children born each year with cerebral palsy, nearly all have disabling impairments; and many of the 617,000 children under age 17 sustaining burns have functional impairment.

The major killing diseases, heart attack, stroke, and cancer, result in disability more frequently than death during the first several years after onset. Each year there are 775,000 new heart attacks, 440,000 new strokes, and 665,000 new cancers detected. As you know, attempts to treat and cure cancer result frequently in considerable impairment and dysfunction.

Appropriate and timely rehabilitation services can reduce disability, and restore function and ability to work for the majority of these people, including the most severely, catastrophically disabled.

REHABILITATION PROCESS

Let us look at the rehabilitation process. Your attention is directed to the appended diagram, entitled, "The Return of Life Functions Following Disability: The Role of Medical Rehabilitation." On this illustration is portrayed the sequences of events which occur over time when an individual sustains serious acute injury or disease.

As you can see on the left, a person functioning normally before disability onset has a high level of life function. This means that he or she has essentially normal physical function, can feed and dress himself, walk and talk, think and act independently, can sustain work and family responsibility, and take part on social, recreational, and all life's other activities.

At the onset of serious acute injury or disease (such as spinal cord injury or stroke), these life functions decrease precipitously. If the insult is very severe all the life functions cease and death ensues. Should the insult be less severe and acute care medicine can effectively deal with the ruptured blood vessels, broken bones, or massive infection, death is averted. Such is the case in the illustration. However, the level of life function is very low at this point; all those activities such as walking, talking, or functioning independently or working are not possible. From this point what happens depends to a large extent on the availability of comprehensive rehabilitation services which can return function to the highest level, in the shortest time and maintain it there for as long as possible. It is possible to document that if little or no rehabilitation services are provided, the course of recovery tends to follow the dotted curve; that is. a relatively low level of life function returns. With comprehensive rehabilitation services provided early the solid line curve results and the outcome is a higher functional level. We will discuss later some of the recent documentary evidence to support these statements.

Required in this intensive rehabilitation process is coordinated multidisciplinary team with the following functions and staff:

Self-care, including eating, dressing, homemaking and prevention of medical complications, is retaught by nurse, occupational therapist, inhilation therapist (when appropriate).

Mobility, including transfer from bed to chair, wheelchair to automobile, et cetera, and ambulation with braces or prostheses is retaught by physical therapist, primarily. Orthotist or prosthetist are needed for device fabrication and fitting.

Communication, including return of speaking, writing and critical assessment of hearing is carried out by speech therapist and audiologist (when appropriate).

Work/School preparation, including prevocational training by occupational therapist and vocational counseling, training and placement by vocational staff, are a critical element in the rehabilitation process, often supported by vocational rehabilitation funds.

Socialization, including reintegration into family and community are carried out by psychologist and social worker. Some teams include a recreation therapist who returns the skills needed to overcome architectural, transportation, and social barriers that impede shopping, socialization, and recreation in the community.

Medical management and coordination are carried out by the team physician.

It should be pointed out that these multidisciplinary teams may be found in many hospitals and all comprehensive medical rehabilitation centers; such an array of services is not provided by skilled nursing facilities (SNF) or by intermediate care facilities (ICF). SNF or ICF are not comprehensive rehabilitation facilities and they cannot have the impact on severe disability that the comprehensive services have. The timing, extent, and intensity of the medical rehabilitation process are unique and overlap little with the role of the SNF or ICF. This distinction should be crystal clear and a national health insurance program inclusive of catastrophic care should reflect this understanding.

EFFECTIVENESS OF COMPREHENSIVE MEDICAL REHABILITATION

The outcome effectiveness of comprehensive medical rehabilitation can perhaps best be measured in terms of increase in level of independent function and return to work. Independent function means ability to move one's self from place to place and take care of one's own eating and dressing without assistance from another person. Work means gainful employment and includes school or homemaking.

Several recent studies, including one requested by Congress, indicate the effectiveness of comprehensive medical rehabilitation on increasing independent function. Importantly, they all find similar results. The level of independent function on admission to rehabilitation is about 35 percent of normal for stroke, spinal cord injury, arthritis, and amputation patients combined. At discharge, function has risen to 70 percent of normal: and at followup, 2–3 years later, it is up to about 75 percent of normal.

Return to "work" following comprehensive rehabilitation for severely disabling spinal cord injury is approaching 70 percent of patients.

Lifetime cost savings in terms of decreased nursing and medical care and increased earnings are now approaching $60,000 per patient following comprehensive rehabilitation for acute spinal cord injury. For the 5,000 Americans with new spinal cord injuries just this year this represents a national lifetime net savings of $300 million; just for careful rehabilitation of one type of catastrophic injury. Can you imagine what similar cost savings might be for all the major disabling diseases and injuries which occur new each year?

Nothing at all has been said about what independence and ability to work means to an individual who has been severely disabled and to his or her family. The returned opportunity for life, liberty, and the pursuit of happiness, is priceless.

CONSEQUENCES OF NOT ADEQUATELY DEFINING REHABILITATION SERVICES COVERAGE

In the past, medicare and other health insurance plans have not adequately defined or specified rehabilitation services and have not provided for comprehensive services, or for the duration actually needed. As a consequence, there has emerged a problem known as retroactive denial of payment of services. The insurance carrier will not pay for certain rehabilitation services delivered or for the duration required because such services or duration are not stipulated in the plan. In some rehabilitation hospitals this has led to very significant loss of revenue or caused the patient or family significant financial hardship.

For example, a number of Federal District Court decisions in the past year have been necessary to reverse HEW determinations that care in rehabilitation hospitals was not reimburseable under medicare. HEW decisions in these cases reflected no understanding of what rehabilitation is and HEW determined that the care provided was either custodial or nursing home care. In every case this past year (five), HEW has lost on the issues and the courts have concluded that the care was necessary rehabilitation care. However, these cases make it clear that the law needs a definition of rehabilitation care, at least as it relates to inpatient rehabilitation to prevent such retroactive denials.

The full extent to which retroactive denial is actually preventing needed rehabilitation services is not known. However, the problem can be overcome with an adequate definition of rehabilitation services and realistic duration of services for the needs of the patient.

RECOMMENDATIONS

It is vital that a national health insurance program provide appropriate coverage of medical rehabilitation services for the disabled.

The American Congress of Rehabilitation Medicine, the American Academy of Physical Medicine and Rehabilitation and the Interspecialty Council of the American Medical Association endorse and recommend the following definition of medical rehabilitation services for inclusion in a national health insurance program:

REHABILITATION SERVICES

(bb) The term "rehabilitation services" means a multidisciplinary approach to services furnished to those with one or more chronic, disabling diseases or injuries under a plan of management directed by a qualified physician related to the achievement of specific outcomes regarding functional capacity or the prevention of deterioration in the disabling condition of the patient; including, where required, any one or more of the following:

(1) physician services, including diagnostic, evaluation and therapeutic services;

(2) physical therapy, occupational therapy, inhalation therapy;

(3) speech pathology and audiology;

(4) prosthetic and orthotic devices, including testing, fitting, or training in the use of prosthetic and orthotic devices;

(5) social and psychological services;

(6) nursing care provided by or under the supervision of a professional nurse;

(7) supplies, appliances, and equipment, including the purchase or rental of equipment; and

(8) such other services as are medically necessary for the mental and physical restoration of the patient, or the prevention of his deterioration, and are ordinarily furnished as rehabilitative services by a hospital or rehabilitation facility.

It should be re-emphasized that current Medicare definitions do not specify coverage of each of these essential services and that unless they are so specified it is unlikely that comprehensive rehabilitation services can be delivered and the expected improvement in life functions achieved, particularly for the catastrophically disabled.

Further, comprehensive rehabilitation services need to be covered as soon after onset of disability as practicable, preferably in conjunction with acute care when that is possible.

Coverage of medical rehabilitation must include in and out patient services to the extent required by the nature of the catastrophic impairment and degree of disability. It is recommended that guidelines of coverage for both type and extent of services be determined by the designated Professional Standards Review Organization (PSRO) through the processes of standards development, utilization review and medical audit.

It will be essential that high standards of care be maintained in the provisions of comprehensive rehabilitation services. Minimal requirements for such care include: 1. A qualified physician managing the care plan; 2. A care plan with clearly defined objectives or goals which are appropriately adhered to.

CONCLUSION

In summary, we support an effective national health insurance program; we strongly recommend that comprehensive medical rehabilitation services be clearly underwritten in such a program; there should be no ambiguity about the intended purpose of the services or the specific type of services required. The testimony here is provided to assist the committee in defining this essential element in our national health insurance plan.

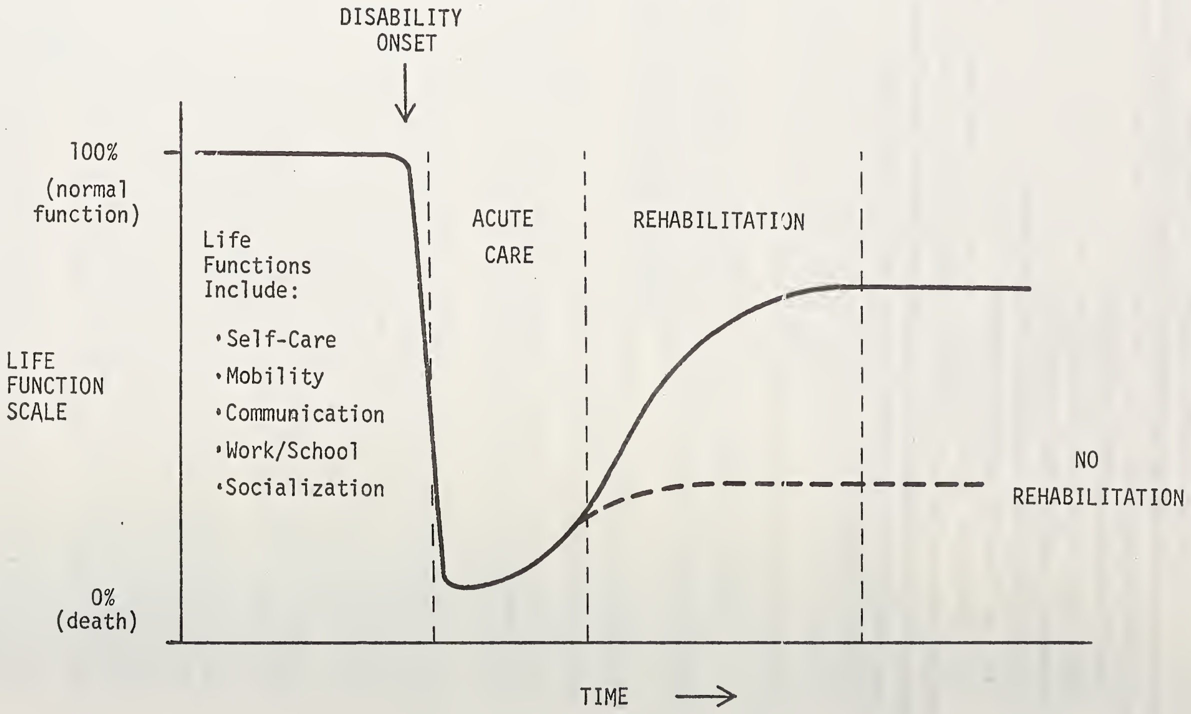
May I leave you with this thought:

Humpty Dumpty sat on a wall;
Humpty Dumpty had a great fall.
All the King's horses and all the King's men
Did put Humpty together again!

Mr. Chairman, this concludes our written testimony, and we are available to answer any questions. Thank you for allowing us to appear before this committee. We are also available at any time to assist the committee in its analysis of the proposals recommended.

[Chart follows:]

THE RETURN OF LIFE FUNCTIONS FOLLOWING DISABILITY
THE ROLE OF MEDICAL REHABILITATION



Mr. ROSTENKOWSKI. Dr. Shapiro.

STATEMENT OF MAYNARD I. SHAPIRO, M.D.

Dr. SHAPIRO. Thank you.

Mr. Chairman, the National Easter Seal Society for crippled children and adults thanks you for the opportunity to testify before this subcommittee today. I am Dr. Maynard Shapiro, a member of the professional advisory council of the National Easter Seal Society, director of physical medicine and rehabilitation at Jackson Park Hospital, Chicago, and a past president of the American Academy of Family Physicians.

The society is one of the major national voluntary organizations providing health care in this country. In 1974, approximately $46 million was expended for health services through programs of the 52 State and territorial Easter Seal societies. A major portion of this sum was expended for comprehensive rehabilitation services, provided essentially on an outpatient basis, by affiliates which own and operate approximately 300 rehabilitation facilities throughout the country. The society has also been active in recent years in providing preventive services, particularly for children. While some rehabilitation programs of the society also include vocational services and special education, today's testimony is directed to comprehensive physical and psychosocial restorative services, and preventive care.

In April of this year, as requested by the subcommittee, we filed a detailed written statement with the subcommittee, discussing the need for improved health insurance coverage for chronically ill and disabled children and adults, the importance of a comprehensive rehabilitation program as part of that coverage, and the need to include outpatient freestanding rehabilitation centers as providers of care. We also endorse the positions taken here today by other witnesses discussing the need for comprehensive rehabilitation coverage.

My testimony today will be brief and will emphasize the following:

1. The shortcomings of the present and proposed systems of financing and delivering health care for the disabled and chronically ill; and
2. Recommendations for correcting these deficiencies, stressing the importance of early detection and restorative care, particularly of disabled children, and improved ambulatory care.

The various proposals put forth to date and the debate about them has all too often focused on questions of financing and support for the traditional patterns of health delivery which have been shaped by Medicare and private insurance. Both Medicare and private insurance have provided financing that accentuated acute care and hospitalization. Neither have provided incentives to diversify the system through the development of programs to prevent or shorten institutional care in hospitals or nursing homes.

The way catastrophic coverage, a needed program, is presently proposed, could exacerbate this situation by encouraging longer hospital stays and more nursing home care. A catastrophic program should provide incentives for alternatives to institutional care, for those with severe illness and disability, such as expanded outpatient rehabilitation. In addition, the financing provisions of the catastrophic programs suggest, with their requirements of annual deductibles and/or coinsurance, an interest in dealing only with the acute, short-term medical catastrophe, not the severe chronic illness or disability whose effects are felt over a long period of time. We would urge that catastrophic coverage focus equally on those with chronic illness and severe disability as well as those with short-term, costly medical care needs. Catastrophic coverage should provide for alternatives to institutional care for these individuals. Some alternatives will be discussed later in my testimony.

As the Chairman has indicated, the national health insurance debate must provide emphasis to those parts of the health care system which are currently undeveloped because of disincentives in present financing programs: preventive care and restorative care. These two aspects of health care are of critical importance to the disabled and chronically ill. Programs of early identification of disability are of particular importance in dealing effectively with the health needs of disabled children. The effects of many disabling conditions could be substantially reduced by early detection and rehabilitative or habilitative care. Dr. Hamilton, who is on this panel, participated in a study dealing with developmentally disabled adults in the Chicago area which indicated that 40 percent of the many disabling conditions encountered could have been significantly ameliorated, if not totally corrected in childhood, by early detection and treatment. The cost savings of such programs for children are enormous.

This issue also relates to a point we have raised before but which needs attention: the relationship between title V of the Social Security Act and national health insurance. Just because a health insurance program covers preventive care is no assurance that those in need will receive the services. A program to support the development of special clinics and other preventive care resources in the community is necessary. Title V may provide this kind of assistance for child health.

With regard to restorative care, we can add no better rationale than that provided by Dr. Hamilton. We can only urge that it would be bad policy to provide so-called catastrophic coverage for the severely ill and disabled, without assuring that such an investment focus on rehabilitative and restorative care for that population. Such a focus will require a clear definition of the medical rehabilitation program to be covered, ranging from post-acute inpatient rehabilitation care, through outpatient care, and home health care. Rehabilitation must be treated as a continuous program and not be fragmented through separate financing programs, as has happened under medicare, parts A and B.

Medicare has also failed to provide adequate care for the disabled because of its eligibility requirements. A disabled person who is not aged must wait 25 months after the onset of his disability before he qualifies for Medicare. By that time, it is too late to remedy the disability.

My final major point involves the need, in health insurance laws, to reshape health delivery systems by expanding the types of programs through which care is delivered. We would urge that any national health insurance program substantially expand ambulatory care alternatives. Recently, a number of bills have been introduced in the House and Senate to expand coverage under Medicare for home health care, outpatient rehabilitation care provided by freestanding rehabilitation centers, and ambulatory day care for those not needing hospitalization or the 24 hour monitoring provided by a nursing home or intermediate care facility. We are supportive of the goals of these bills. Of particular significance are H.R. 8038 and S. 2506, introduced by Congressman Mikva and Senator Ribicoff (with 17 cosponsors), respectively, to expand part B outpatient rehabilitation benefits, S. 2591 introduced recently by Senator Bentsen to expand home health care and ambulatory day care as alternatives to post-hospital, extended care and other nursing care, and H.R. 10324 (and similar bill H.R. 10422) introduced by Congressmen Koch and Pepper dealing with home health.

The existence of these bills clearly indicates the deficiencies in the current programs. There must be a total study of the need for alternatives to hospitalization and nursing home care during any consideration of national health insurance. We believe a major mistake would be made if national health insurance emulated Medicare regarding the benefit structure. As we have already pointed out, continuing a Medicare system provides incentives toward greater hospitalization. As the interest in the bills mentioned above indicates, the Medicare B program needs substantial expansion in terms of days or visits covered, and equally important is the need to provide incentives for ambulatory care. Home health and outpatient care can substitute for hospital care through preventing a need for it, or providing an alternative to it, and thereby shortening hospital stays.

The emphasis in current insurance programs on acute care and institutional care can best be redirected through the following new initiatives in a health insurance program:

(1) Preventive programs for both children and adults focusing on early detection and treatment of disabling conditions;

(2) Expansion of comprehensive outpatient rehabilitation care in freestanding rehabilitation centers after, or in lieu of, inpatient care;

(3) Expansion of other comprehensive ambulatory care programs for the chronically ill or disabled child or adult who can reside at home, such as home health or medical day care programs providing skilled nursing and rehabilitative care, as well as meals and recreation where needed;

(4) Coverage for inpatient rehabilitation care where necessary to provide a comprehensive, continuous program for the severely disabled and chronically ill.

A program such as has been outlined above will do much to assist in complete restoration for the disabled, with the ultimate objective of reintegrating such individuals into community life, including, where possible, employment or education.

We appreciate being able to testify today and we deeply appreciate the work of this subcommittee in attempting to fashion a comprehensive health care program for all Americans.

Mr. ROSTENKOWSKI. Thank you, Dr. Shapiro.

Mr. Hipkens?

STATEMENT OF T. P. HIPKENS

Mr. HIPKENS. My name is Ted Hipkens. I appear before you today as the Director of the Association of Rehabilitation Facilities, as well as a person with a long and varied involvement with the health care field.

The Association of Rehabilitation Facilities is a voluntary membership organization consisting of about 640 rehabilitation facilities. Some of these facilities are freestanding; some are parts of hospitals or clinics; some are both inpatient and outpatient; some outpatient only. Some are heavily medically oriented, some heavily vocationally oriented, each with shadings in between. All have the common mission of serving handicapped individuals, particularly those who are severely handicapped.

I speak also as one who during the recent past has been the president and chief executive officer of a three-State health care system in central Appalachia. This system consisted of providers of several levels of health care (hospitals, group practice-oriented clinics, extended care facilities, home care units, et cetera). In that system we provided first-rate care, but it is important to note that this first-rate care we provided was sickness or trauma-response care and not health care. We were picking up the pieces or patching the presenting wound. We were only beginning to nibble at the vast potential available through the utilization of rehabilitation principles and procedures as applicable. There was particular potential for the use of preventive habilitation or preventive rehabilitation measures. This potential existed for a significant number of our patients of all ages.

There were many reasons for this service lack or service deficit, but one of the principal ones was the presence of skewed priorities in the allocation of health care dollars, as reflected in the financing parameters of both public funding and insurance sources.

Let me cite a couple of not-so-hypothetical illustrations.

At one of our installations in Appalachia, with the assistance of some Johnson Foundation funds and deficit financing, we instituted a program of early identification and intervention with new mothers and newborns. Almost at once, we detected a significant number of failure-to-thrive infants, several severely damaged babies and several with early signs of incipient major developmental or critical health-threatening problems. For all of these, according to their needs, multiple rehabilitation-oriented services were instituted. These programs were rehabilitation-oriented in the sense that often with health impaired individuals, there exists or develops, a constellation of obstacles around the impairment that inhibits recovery or improvement: nutritional problems, family inadequacies, substandard living arrangements, to name some. Rehabilitation principles dictate an integrated assault on all of the obstacles; for failure to heed one might well prevent success or insure failure with the others. We're talking here of several thousand babies in this one community of whom a significant number would surely have ended up severely handicapped and perhaps permanent residents of State institutions, useless to themselves and others, if we had persisted in doing it the same old way.

Sadly, only 1 of our 10 hospitals provided this service. Under the current antisystem of health care delivery, countless thousands of comparable infants and children are being denied these rehabilitation services, primarily because of skewed financing priorities.

At the other end of the life spectrum, visualize the person who suffers a stroke and survives. In most instances, the early institution of rehabilitation measures, even at the present state of the art, can go a long way toward materially reducing the ultimate level of impairment as well as the ultimate level of impact of all the obstacles that may come to play; language problems, ambulation problems, emotional problems, family reactions, the nature of family involvements; even reemployment or homemaker capacities. It has long since been conclusively demonstrated that early institution of comprehensive rehabilitation services (and sometimes subsequent, selective, intermittent, reinstitution) can go a long way toward maximizing the final functional viability of the individual. Conversely, it has been shown that failure to provide this comprehensive preventive rehabilitation sequence can result in a much lower residual functional status.

Again, as with the infants, many persons so affected, as well as countless thousands of impaired and handicapped individuals from a variety of health or health-related assaults are denied access to comprehensive rehabilitation, in part, by reason of skewed financing priorities.

It is, therefore, submitted that in considering any change in methods of financing (in the name of health care) that along with a greater emphasis on all elements of prevention in general that such prevention thrust should be augmented and guaranteed by legislative language that insures and encourages an enlightened approach to the utilization of modern, comprehensive rehabilitation services. Such action does not necessarily mean more money; but rather a reordering of priorities in the assignment of dollars spent (in the name of health care).

When I speak of doing it the same old way, I speak particularly of continuing to emphasize the provision of high cost acute care and the failure to follow through with rehabilitation and related services to restore a disabled or injured person. Nowhere is this failing more currently manifested than in the medicare program. When medicare was passed. it was designed to pay for hospital care—a worthy and humane objective; however, you get what you pay for and thus what we have gotten is high cost care for medicare beneficiaries. This in turn has led the Congress and Social Security Administration to begin to limit medicare reimbursements through a variety of restrictions designated to contain rapid escalation of medical costs. On a more positive note the Medicare Act has been amended periodically to allow payment for outpaient services, but it continues to be essentially an inpatient acute care program. Since most national health insurance bills pending before this committee incorporate this medicare benefit restriction on our hospitals and rehabilitation facilities, there is considerable danger that this basic failing will be perpetuated in NHI legislation.

The Association of Rehabilitation Facilities has, over a period of time, called to the attention of this committee the need for coverage of a full range of rehabilitation services both on an inpatient and outpatient basis in the medicare program, or any NHI program.

Congressman Mikva has introduced legislation to amend title XVIII to achieve these goals. I would commend his bill, H.R. 8038, to you, both as a quality amendment to title XVIII and also as good language to be incorporated in NHI bills.

I wish to call your attention to one other failing which is common to the various bills which have been introduced under the general heading of NHI. Most purport to provide for preventive and restorative services for children presumably to attack potential handicaps at the earliest possible time and thus reduce long-term dependency and high cost of acute care. Obviously, we support this objective. I believe, however, that simply providing payment for preventive services for children will not assure that such services are provided to those children and families who are the least likely to receive them in the current scheme of things.

Aside from the considerations of cost control and delivery management, primarily our reason for appearing before this committee considering NHI, is because not everyone is getting adequate health care through the current basic insurance system. Most of the people who are not getting good care now are the poor and near poor and are the same people who are the least likely to seek out and obtain preventive and restorative services for children even if coverage is provided through insurance programs. Accordingly, we urge that, in drafting a new bill, this committee address itself to the need for a more positive and aggressive approach to the early identification and treatment of potentially handicapping conditions in children through amendments to title V of the Social Security Act and by provision for funds to be channeled to public health agencies, rehabilitation agencies, and other institutions for outpatient rehabilitation and treatment programs.

I could talk about the terrible toll in human misery that will continue with many severely handicapped humans, if we persist in doing it the same old way, with just more money for the same old things.

I could talk about the terrible waste of manpower represented by handicapped citizens whose level of functioning will be much less than it needs to be, if we persist in doing it the same old way.

I could talk about an experiment of the Pennsylvania State Workmen's Insurance Fund that demonstrated the dollars and cents value of early rehabilitation measures for injured workers, instead of doing it the same old way.

Surely, you know all this from others. So in conclusion, it seems to me, that if we have to settle for no more than better financing rather than a better delivery system, the least we can do is reshuffle our priorities to get better performance within the present framework.

There is a need to spell out in clear legislative language the commitment to the important role of rehabilitation in "health care" to include incentives that will encourage health care providers and users to insist upon "doing it a better way," and in the process to accumulate some operating experiences that down the line will surely point the way to a more extensive overhaul of our entire "health delivery system" and not just its financing element.

The Association of Rehabilitation Facilities is prepared, along with a number of similarly oriented associates, to provide professional and technical assistance to you and your staff as you put together the necessary legislation that will hopefully achieve the goals we espouse. We hope you will call upon us!

We're most appreciative of this opportunity to share our views with you and would be most happy to respond to questions.

Mr. Rostenkowski. Thank you, Mr. Hipkens.

Dr. Goldensohn, I think we will recess until 1:15. I don't want to allow you to proceed into half of your testimony. So, the committee will stand in recess until 1:15, only because we do have a piece of legislation on the floor.

[Whereupon, at 11:45 a.m., the hearing was recessed to reconvene at 1:15 p.m.]

Afternoon Session

Mr. Rostenkowski. Will our panelists please take their places?

Thank you for your patience. Dr. Goldensohn, if you will, begin with your testimony.

STATEMENT OF ELI GOLDENSOHN, M.D.

Dr. Goldensohn. Mr. Chairman, distinguished members of Congress, and esteemed colleagues in the health field, I am Eli Goldensohn, a board certified neurologist and practicing physician. I am professor of neurology at Columbia University College of Physicians and Surgeons and attending neurologist at Presbyterian Hospital in New York City.

Today, I am privileged to represent the Epilepsy Foundation of America, as chairman-elect of the professional advisory board and a member of the board of directors. The Epilepsy Foundation of America, headquartered here in Washington, serves as national advocate and spokesman for the estimated 4 million Americans afflicted with epilepsy.

A critical problem in health care of the people with epilepsy whom we represent, is that, as a group, they cannot obtain health insurance and they and their families are often pauperized by the tremendous cost of medical treatment. If adequate national health insurance with continuing first-class medical services were available to all people with epilepsy, their social contribution, rate of employment, educational and technical development, dignity as individuals, and stability within their family structure would be immeasurably strengthened.

Since the earliest records of written history, epilepsy has been recognized as a major health problem. The word itself comes from the Greek and means "to be seized." Hippocrates, in the fifth century B.C. gave accurate descriptions of major and minor seizures and described the attempts of patients to hide their affliction from others. Today, as in the past, the psychological problems of a person with epilepsy are manifold and serious, depending on the type of seizures and the degree of rejection by society. If the person suffers from other disabilities as well, his problems are compounded.

Although an epileptic attack still generates unreasonable fear in some observers, there is nothing mystical about this disorder. Basically, epilepsy is a disorder of the nervous system, usually characterized by recurrent, complete or partial loss of consciousness, and accompanied by bodily movements ranging from simple twitching of a few muscles to gross shaking of the entire body. The epileptic seizure is the result of abnormal discharges of populations of brain cells which become excessively irritable as the result of injury or disease. Such a seizure may last from a few moments to several minutes and is chronic over many years or a lifetime. Consequently, the cost of medical care to the patient and his family are often unbearable.

Precisely what kind of financial burden does epilepsy place upon the average patient? He has a seizure and goes to a physician for diagnosis, and that costs. He has another attack on the street and is taken by ambulance to a hospital emergency room, and there are additional charges. His diagnostic tests are expensive; an electroencephalogram to record the electrical activity in the brain, blood tests to look for other possible causes of unconsciousness or convulsions such as hypoglycemia or diabetes, and skull X-rays, including the new computerized transaxial tomograms to examine his brain for possible damage or a tumor. Add to this the cost of hospitalization for treatment and further laboratory examinations and the expense can be staggering.

After the diagnosis of epilepsy is established, medication must be taken daily. The average annual cost, $178 per patient, was determined in a survey by the EFA last year. This expense almost always continues for many years or for the lifetime of the person with epilepsy. Periodic visits to the physician are necessary for changes in dosage of medication for optimal control of the seizures and toxic signs as well as to recheck on the basic causes of the seizures. At intervals electroencephalograms and gas-liquid chromotography tests are needed to indicate whether epileptiform activity is still present in the brain and whether prescribed medication is at the therapeutic levels.

What does all this mean when the medical bills come due? According to estimates of the National Institute of Neurological and Communicative Disorders and Stroke, the average annual cost is $500 per patient. Multiplying this $500 by the estimated 4 million citizens with epilepsy in our country gives an annual cost of $2 billion.

How do these patients presently pay for this? Last year, the EFA published a study, "The Cost of Epilepsy to Individuals, Families. and the Nation." If we look only at the medical side of the problem, the study concludes that in 1972 medicaid paid $31,300,000 in benefits to persons with epilepsy, medicare paid $6,265,000, the Veterans' Administration paid $27,750,246, and the crippled children's program spent $4,700,000 for a grand total of $70,015,000, or 3½ percent of the total medical expenses. Conversely, 96½ percent of the medical expenses are borne by the individual or by commercial insurance companies.

What are the individual resources for meeting the other $1.299,985,000 in annual medical expenses for treatment of epilepsy? Other than the patient's own pocket, very few. A recent survey (1972) conduced by the EFA showed that over one-half of the patients with epilepsy (53.2 percent) had none of their medical expenses paid by insurance and only 8.3 percent had all or nearly all of their medical expenses covered by insurance. Thus, of the 4 million people with epilepsy, 91.7 percent or 3,868,000 have little or no health insurance.

A major problem confronting persons with epilepsy is that of obtaining health and disability insurance. Frequently the person with epilepsy is either summarily denied coverage or must pay an exhorbitant amount in premiums. The Epilepsy Foundation of America conducted a survey (1973) of 400 persons whom the foundation identified as either having epilepsy themselves or having children with the disorder. Of those queried, 30.1 percent reported that they had trouble obtaining health and accident insurance. Of those medically and legally eligible to drive, 15.7 percent reported problems in obtaining automobile insurance.

Of the many thousands of poignant communications reaching the Epilepsy Foundation of America and its 161 local chapters, a large number address themselves to the problems of obtaining insurance.

I would like to read three brief excerpts from letters that illustrate the frustration and dilemma imposed on persons with epilepsy and their families.

> Yesterday I attempted to purchase health and hospitalization insurance from a major company. Because I had grand mal epilepsy when I was younger, they refused my application. It has been four years since my last spell.
>
> The agent trying to sell us the insurance plan described on the enclosed brochure backed off quickly when he learned our child had a seizure—now under control with medication. Is this the usual story on insurance for persons with epilepsy?
>
> Upon trying to apply for life insurance and disability insurance to some of the major companies, my husband and I have found that to insure someone who has epilepsy they require double and triple premium rates and expect to still include a waiver clause for epilepsy. Could you supply us with names of any good companies that are not quite so discriminatory?

In the area of health insurance, it is obvious that the person with epilepsy is restricted as to the amount of coverage and the types of policies which are available. In most cases, the applicant who has had some form of epilepsy can expect to pay an additional premium for health insurance coverage, and in some instances, no coverage at all will be available. Long term disability income coverage and major medical protection are often either not offered to persons with epilepsy or only to those with mild forms of this disorder. Resistance to granting insurance must in part be ascribed to the tragic misunderstanding and social stigma that still plagues the person with epilepsy.

In some instances, the person with epilepsy is able to purchase health insurance with the restriction that any preexisting disability, that is, epilepsy, will not be covered, or will be covered, perhaps partially, after a substantial waiting period. Thus, the person is insured for everything except the health problem to which he is likely to be bound for the rest of his life.

The health needs of persons with epilepsy show a long-term history of denial, exclusion, and discrimination. The essential problem remains that the people we represent need good health insurance and cannot get it. National Health Insurance can be the first real opportunity to provide a person with epilepsy with the coverage he so vitally needs.

I am submitting for this committee's further study, additional data "The Cost of the Epilepsies, to Individuals, Families and the Nation; Behind the Stigma of the Epilepsies; Epilepsy and Insurance, and Basic Statistics on the Epilepsies" for inclusion in the published report of these proceedings.

On behalf of the estimated 4 million Americans afflicted with epilepsy, I thank this committee for the opportunity to endorse national health insurance and to present our special needs for your consideration in designing a workable system of health care services.

I shall be happy to answer any questions you may have.

Thank you.

[The prepared statement follows:]

STATEMENT OF ELI GOLDENSOHN, M.D., EPILEPSY FOUNDATION OF AMERICA

Mr. Chairman, distinguished members of the Congress and esteemed colleagues in the health field, I am Eli Goldensohn, a Board Certified Neurologist and practicing physician. I am Professor of Neurology at Columbia University College of Physicians and Surgeons and attending neurologist at Presbyterian Hospital in New York City.

Today, I am privileged to represent the Epilepsy Foundation of America, as Chairman-Elect of the Professional Advisory Board and a member of the Board of Directors. The Epilepsy Foundation of America, headquartered here in Washington, serves as national advocate and spokesman for the estimated four million Americans afflicted with epilepsy.

Basically, epilepsy is a disorder of the central nervous system characterized by a recurrent loss or impairment of consciousness which may be accompanied by muscular movements ranging from a simple twitching of the eyelids to a convulsive shaking of the entire body. It can result from many different diseases or injuries. Depending on the type of epilepsy, seizures may last from ten to thirty seconds or from five to fifteen minutes, and the frequency can vary from one every year or so to several a day.

Psychological problems faced by the person with epilepsy vary greatly depending on whether he suffers from petit mal, grand mal, or psychomotor epilepsy. If the person suffers from other disabilities as well, additional problems may present themselves. Also the person whose seizures are well controlled may have different problems from those whose seizures are poorly or moderately controlled.

Epilepsy has been observed ever since written records of history were first invented. The word comes from the Greek word meaning "to be seized." The writings of Hippocrates, in the fifth century B.C., contain the first definitive descriptions of major and minor seizures. Famous people such as Alexander the Great, Julius Ceasar, Buddha, Napoleon, Tchaikovsky, and Dostoyevski were thought to have epilepsy.

Epilepsy cannot be "cured" per se. Patients can achieve control of their seizures in a large majority of cases through the use of medication.

What kind of a financial burden does epilepsy place on the average patient? Let me condense a lifetime of medical treatment for epilepsy for you into a few words. A person has a seizure. He goes to a physician for diagnosis and that costs. If he winds up in a hospital emergency room via an ambulance, there's an additional cost. He has diagnostic tests run—an electroencephalogram to record electrical activity in the brain; a blood series to look for other reasons for unconsciousness or convulsions such as hypoglycemia or diabetes: skull X-rays to look for possible damage to the brain such as a tumor. These tests are by no means inexpensive and may also entail a stay in the hospital, the cost for which we all know is rising almost daily.

Then the physician arrives at a diagnosis of epilepsy and prescribes medication, and that costs too—an average annual cost of $178 per patient was determined in a 1974 survey by EFA. And those costs almost always continue for the rest of the person with epilepsy's life—one or two visits to the physician each year, if all goes well; perhaps as often as weekly if the seizures are not well controlled. Medication every day for the rest of his life: periodic electroencephalograms and gas-liquid chromotography tests to determine if epileptiform activity is still present and if prescribed medication is at a therapeutic level. What does all this mean when the medical bills come due? An average annual cost of $500 per patient is what the National Institute of Neurological and Communicative Disorders and Stroke estimates and that adds up to a $2 billion annual cost in normal medical care for an estimated 4 million citizens of this country. National Health Insurance would greatly alleviate this burden.

And how do these patients now pay for this? In 1974, the EFA published a study titled "The Cost of the Epilepsies to Individuals, Families and the Nation."

If we look only at the medical side of the problem, the study concludes that in 1972 (the latest year for which comparable figures are available) Medicaid paid $31,300,000 in benefits to persons with epilepsy, Medicare paid $6,265,000 in benefits to persons with epilepsy, the Veterans Administration spent $27,750,246 in medically treating veterans with epilepsy and the Crippled Children's Program spent $4,700,000 on medical services for children with epilepsy. This totals $70,015,000, leaving $1,299,985,000 of the total $2 billion in medical costs to be borne by the individual, or commercial insurance companies.

What are his resources for meeting these very necessary medical expenses? Other than his own pocket, almost none. A 1972 survey of epilepsy patients conducted by EFA showed that 53.2% of the patients surveyed had none of their medical expenses for epilepsy paid by insurance; 15% had seventy-five percent paid by insurance and only 8.3% have ninety-nine to one hundred percent of their medical expenses for epilepsy covered by insurance.

Among major problems still confronting persons with epilepsy, is that of obtaining adequate insurance. Quite frequently, the person with epilepsy is either summarily denied coverage or must pay an exorbitant amount in premiums.

In 1973, the Epilepsy Foundation of America conducted a survey of 400 persons whom the Foundation could positively identify as either having epilepsy themselves or having children with the disorder. Of those queried, 33.8% reported that they had trouble obtaining life insurance and 30.1% reported that they had trouble obtaining health and accident insurance. Of those eligible to drive, 15.7% had problems obtaining automobile insurance. Of the thousands of inquiries reaching the Epilepsy Foundation of America and our 161 local chapters, many address themselves to the problems of insurance.

EFA, its Board of Directors, Professional Advisory Board, Officers, and local chapters have recognized this need and through its own efforts has been able to make term life insurance available to its members at rates substantially below the market average. The key feature of EFA's Group Life Plan, which is underwritten by Government Employees Life Insurance Company (GELICO) an affiliate of GEICO, is that the person with epilepsy, so often automatically denied all other types of insurance, is eligible for coverage under this program.

But this breakthrough solves only one aspect of the insurance problem for persons with epilepsy and the Foundation is looking into automobile, health and disability insurance as well. Provision for the coverage of persons with epilepsy under National Health Insurance would help to solve this major dilemma.

I would like to read three excerpts from letters that illustrate the frustration and dilemma imposed on persons with epilepsy.

"Yesterday I attempted to purchase health and hospitalization insurance from a major company. Because I had grand mal epilepsy when I was younger, they refused my application. It has been four years since my last spell. The company said the epileptic condition never clears up, but I feel they are not correct."

"The agent trying to sell us the insurance plan described on the enclosed brochure backed off quickly when he learned our child had a seizure—now under control with medication. Is this the usual story on insurance for persons with epilepsy?"

"Upon trying to apply for life insurance and disability insurance to some of the major companies, my husband and I have found that to insure someone who has epilepsy they require double and triple premium rates and expect to still include a waiver clause for epilepsy. Could you supply us with names of any good companies that are not quite so discriminatory?"

While it may be true that some persons with epilepsy represent a substandard risk, the insurance companies are generally unable to evaluate all applicants with epilepsy fairly because they have no accurate statistics on mortality and accident rates for persons with epilepsy. Accurate statistics would be difficult to obtain currently because thousands of insured with epilepsy do not *acknowledge* that they have some form of epilepsy in applying for coverage—because of the tragic misunderstanding and social stigma that still plagues the person with epilepsy.

The lack of progress in this field, as well as in many others, is undoubtedly due to a lack of knowledge and understanding of the disorder, as well as a lack of experience in underwriting insurance for persons with epilepsy.

In the area of health insurance, the person with epilepsy is restricted so far as to the types of policies and amount of coverage which are available. The applicant who has had some form of epilepsy can expect to pay an additional premium in most cases for his health insurance coverage, and in some instances no coverage will be available. For example, long term disability income coverage and major medical protection often are not offered to persons with epilepsy or only to those with mild forms of this disorder.

In some instances, a person with epilepsy may be able to purchase health insurance policy with the restriction that any pre-existing disability, i.e. epilepsy, will not be covered, or will be covered, perhaps partially, after a substantial waiting period. Thus the person is insured for everything *except* the health problem that presents a financial burden and one which he can expect to have for the rest of his life.

The health needs of persons with epilepsy show a long-term history of denial, exclusion and discrimination. National Health Insurance is the first real opportunity to provide the person with epilepsy with the coverage he so vitally needs.

I am submitting for this Committee's further study additional data (*The Cost of the Epilepsies, to Individuals, Families and the Nation; Behind the Stigma of the Epilepsies; Epilepsy and Insurance*, and *Basic Statistics on the Epilepsies*) for inclusion in the published report of these proceedings.

On behalf of the estimated four million Americans afflicted with epilepsy, I thank this Committee for the opportunity to present our special needs for consideration in designing a viable and workable system of health care services.

I would be happy to answer any questions you may have. Thank you.

Mr. ROSTENKOWSKI. Thank you, Doctor.

Mr. Hoffman.

STATEMENT OF CHARLES A. HOFFMAN

Mr. HOFFMAN. Mr. Chairman, my name is Charles Hoffman. I live in Islip Terrace, New York. I am a salesman in the printing, advertising, and direct mail fields.

I represent no groups, no foundations, no clients, no lobbyists; no one but myself. I am here in Washington today because I feel so strongly that the United States Congress should pass a national health bill.

The next comments I don't have written down, but I would like to refer to them. My family had no major medical insurance when our problem came up with our baby. At this time, my family is broke. We owe a hell of a lot of money. My wife still has and had a physical breakdown as a result of our baby's problem—called spastic colitis. I had a mental breakdown which affected me for over one year from which I have just recovered. My doctor and I agreed that I was completely recovered, and I go back to work this week.

I find from our experiences in the last 2½ years that the doctors on Long Island, N.Y. are very jealous of Dr. Denton Cooley—and other Houston, Tex., doctors—and, I think, jealous of superior doctors in general.

I will comment that all the doctors we know personally, and I have grown up in a professional family, and not one doctor suggested that we should get a second opinion. If only one of them had opened their mouths, we could possibly have saved some of the nightmares we lived through.

I feel that clinics should be set up so that people can be encouraged to have their illnesses cared for as they occur, as well as the fact that "annual checkups" are of tremendous importance in discovering illnesses before they become critical.

Such clinics should be open "evening and weekends" and it is my opinion that it should be set up so that these clinics are associated with "teaching hospitals" and "teaching clinics." It is a known fact that proper checkups can prevent serious illnesses in many cases and in reality—medical and dental costs can be lowered by a system of "medical and dental maintenance" of the human body.

Areas of the country that have too many hospitals within a "local area" all performing cardiovascular surgery should be studied carefully. Where such areas exist—elimination of too many of these duplications of heart hospitals should take place (there is no need for many hospitals to have a cardiovascular "team" except as an EGO situation/prestige with needless moneys being spent).

Doctors, dentists, paramedics, dental hygienists, et cetera, should be hired on a full-time basis (no outside practice allowed) to provide "proper care."

The Government shall make grants for research on cancer, kidney, diabetes, heart, Parkinson's, et cetera. If the United States can send men to the Moon, then surely we can spend money to save lives.

Elimination of redtape in getting medical and dental treatment. Set up guidelines but keep the redtape to a minimum. Use of the social security card would and should be the ideal solution.

Set up a national insurance program with moderate costs. Perhaps a national lottery with the money really going into this insurance fund might be a possibility.

Legislation should provide protection for patients treated by incompetent physicians, and also very important, home health care should be available for families, as many times parents or spouses must live in the hospitals many times when surgery takes place.

This occurred in our family. My wife lived in a hospital room for about 21 days with Seth when he had his open heart surgery.

Ten days ago—on Thursday, November 6, 1975, I had the satisfaction of hearing that the "eminent, world-reknowned" cardiovascular surgeon, Dr. Denton Cooley, of Houston, Tex., had successfully performed another open heart operation on a 1-year-old baby.

I say "satisfaction" because that baby went to Houston, Tex., from Long Island, N.Y., because of my (and my wife's) endeavors. It took that baby's parents only 3 weeks to get an appointment for the open heart surgery with Dr. Cooley. In New York City, at Columbia Presbyterian Hospital, the minimal wait would have been 5 months.

Twelve days ago, on Tuesday, November 4, 1975, I called my son's new pediatric cardiologist to tell him that he should note on my son's medical records the fact that I have diabetes. I mentioned to this cardiologist that I had just returned from a week's stay at the Joslin Clinic at the New England Deaconess Hospital in Boston, Mass. Dr. Reitman replied: "You certainly believe in going 'to the best' medical experts for everything, don't you?" And I replied: "I will do no less for myself than I did in saving the life of my son."

Seth Adam Hoffman, my baby son, who is now 2½ years old, should be dead. And he would be dead if my wife and I had listened to Seth's first pediatric cardiologist, and Seth's first cardiovascular surgeon. These two "specialists" practice on Long Island, N.Y., and they both treated my son, after his birth, incompetently.

I don't mean to sound dramatic. I am stating a fact. My son was born with a congenital birth defect called transposition of the great vessels. This means the two main arteries were reversed in his body.

Scientists don't know what causes this. It is the second worst heart condition possible.

After Seth came home from the local cardiac hospital (St. Francis Hospital, Roslyn, N.Y.), after undergoing closed heart surgery (successfully), (Seth was 2 months old when he had this closed heart surgery, by the way)—he developed a condition called pulmonary stenosis, a condition that both of the "specialists" treating him should have known about; particularly after we complained so much, so continuously. (Pulmonary stenosis, itself, alone requires open heart surgery.)

For the record, I have brought with me copies of an 8-page brochure. The first 5 pages pertain to a story which appeared in the Sunday magazine section of Newsday (a sister newspaper of the Washington Post.) Seth's picture appeared in living color on the front cover that Sunday.

This brochure is for "informational purposes only" and has been reprinted with the kind permission of Newsday. On page 8, I reproduced an article that appeared in Newsday, on page 6, in the July 25, 1975, issue. This story tells about my unsuccessful 5-month fight with the New York State physically handicapped children's program officials; a fight I was forced to give up because of my health.

Pages 6 and 7 of this brochure contain my personal comments about my son's condition and his future.

I had only recovered some months previously from a mental breakdown; a condition brought on by my son's illness. With help from a competent psychiatrist I regained my mental health this past spring, but it is only now, in November, that I am able to return to work.

Members of Congress, I implore you to consider the feasibility of including in the health bill a department called: The national physically handicapped children's program. Any baby born with a congenital birth defect should be automatically placed onto this program, regardless of the income or the assets of the parents.

Furthermore, each and every child born with a congenital birth defect should be registered onto this national physically handicapped children's program by the hospital where the baby is born, at the time of the baby's birth.

Any child with a congenital birth defect not only should be automatically placed on this program, but the child should be allowed to go to any hospital in the United States to get the best medical care possible. Not like now, in 1975, in New York State (and many other States), where the State law prevents some parents from getting proper medical care because the State is trying to keep their local hospitals filled. In fact, many States do not even have a physically handicapped children's program at all.

New York State has 23 approved cardiac hospitals. St. Francis Hospital, Roslyn, N.Y., is one of these; and it was here that Seth had his closed heart operation—at the age of 2 months—and it was here that he was scheduled to have his open heart surgery performed. This hospital's fatality rate for 1973 was so bad the administrator would not even release it for publication; in 1974, St. Francis' fatality rate was 10 percent (the worst acceptable rate deemed proper for a heart hospital). Quite frankly, St. Francis Hospital does not perform enough open heart operations each year so their surgical teams can get the proper training.

St. Francis is so bad with its results with transposition babies undergoing open-heart surgery that the local pediatric cardiologist is not recommending this hospital, anymore, when his patients need the open-heart surgery. Yet, this hospital would have been where Seth would have had his open-heart surgery performed if we had not gone to Houston, Tex., against the wishes of our "former" pediatric cardiologist, Dr. Thomas McLoughlin.

But was Seth Hoffman allowed by the State of New York to go to Dr. Cooley in Texas? The answer was no. Well, the Hoffmans said to New York State: "To hell with your program, we are going to Dr. Cooley." And the medical costs for surgeons and hospital came to under $30,000, about 50 percent less than the costs would have been in any of the 23 approved New York State cardiac hospitals. Besides, not one hospital outside Houston, Tex., can boast of having a cardiovascular surgeon on its staff who has performed over 10,000 open-heart operations. Dr. Denton Cooley, of the Texas Heart Institute, Houston, Tex., performed his 10,000th open-heart operation in 1972.

It tells about, on the back page, my unsuccessful fight, which I was forced to give up because of my health.

The story about the ordeal my wife and I went through was not embellished in anyway by the reporter. Every word told it like it was.

It is my feeling that a family shouldn't have to spend their life's savings when a catastrophic illness hits some one member of that family. And the general public does not realize also, that many times other members of the immediate family can become ill due to the patient's illness.

Unfortunately, most of you cannot relate to the experiences my family went through; or the experiences that many other individuals and organizations are testifying to, at these hearings.

Yes, you can be extremely sympathetic. You can be understanding. You can feel empathy. But you cannot relate to me, my emotions, my frustrations, my nightmares, unless you, yourself, live through such a nightmare, as I have.

When drawing up a health bill, I hope you will give consideration to my proposed national physically handicapped children's program. Information about this proposed program should be disseminated to every pediatrician's office throughout the United States. Our own pediatrician never heard of the New York State program. In addition, information should be disseminated by every public library and by every kindergarten teacher and school nurse in the country.

Good medical health and good medical treatment should not be a luxury for the rich, nor should it cause families to spend any and all the money they have in the world, but rather it should be available to every citizen of these great United States as a given right.

The cost for such a program as I propose would not be exorbitant as compared to what it costs the county, State and Federal Governments now not to have such a program. I mean welfare, medicaid, and so on. I am paying over $600 a year now for Blue Cross and Blue Shield premiums. And half of my medical and all my drug expenses are not even covered by Blue Cross and Blue Shield. Unless something is done soon, I will not even be able to afford to pay their premiums because their increases keep going up a hell of a lot faster than the cost-of-living index rate.

It should be noted that I indicate that my proposed national physically handicapped children's program should be geared to newborn babies. I would settle for even that much. If this was done, my family and my son won't gain 1 cent from such a program, and I would be satisfied. But I hope that your committee will consider the existing thousands and thousands of sick children throughout the United States to be eligible for such a program as I propose. The program should not just be limited to heart-problem children, but to all sick children with congenital problems.

At this time I am fortunate to now have major medical insurance for my family and Seth. And you have insurance for your families. But what about all those tens of thousands of families who don't?

I truly hope that you will read my appended eight-page informational brochure. The March 1975 article ends with the comment that my wife and I are available if any families with a heart baby wished to call or write. Even now, over 6 months later, we occasionally get a stray letter or phone call. And today, I say to all of you:

> If you do consider the feasibility of establishing a national physically handicapped children's program, I will make myself available to be of help or to lend my support in any way I can to your committee or whatever department works on such a program.

By the way, you might like to know that my wife and I don't know how long our baby son will live. He may live 1 month, 1 year, 5 years, or 50 years. His condition, transposition of the great vessels (reversed arteries), is the second worse heart problem; and as an illness it has no track record. In 20 years, Seth Adam Hoffman will be a part of the statistics that will enable doctors to quote to future families at that time. Now, with our son, we can only be optimistic.

Thank you for allowing me to come here today.

Mr. ROSTENKOWSKI. Thank you, Mr. Hoffman. Without objection, the article in Newsday magazine will be included in the record.

[The summary of recommendations and article follow:]

SUMMARY OF COMMENTS AND RECOMMENDATIONS OF CHARLES A. HOFFMAN, ISLIP TERRACE, N.Y.

I comment that Dr. Denton Cooley and his Texas Heart Institute (Houston, Texas) are the "best surgeon and hospital" in the United States for Cardio-Vascular Surgery (open heart surgery).

I comment on a "heart condition" called Transposition of the Great Vessels and the fact that this Congenital Birth Defect can also lead to a further "heart defect" called Pulmonary Stenosis.

I comment that I am in favor of a "national health bill." Such a "bill" should cover every child and every adult for medical and dental care "from birth until death".

(1) Clinics should be set up so that people can be encouraged to have their illnesses cared for as they occur, as well as the fact that "annual checkups" are of tremendous importance in discovering illnesses before they become critical.

(2) Such clinics should be open "evenings and weekends" and it is my opinion that it should be set up so that these clinics are associated with "teaching hospitals" and "teaching clinics". It is a known fact that proper checkups can prevent serious illnesses in many cases and in reality—medical and dental costs can be lowered by a system of "medical and dental maintenance" of the human body.

(3) Areas of the country that have too many hospitals within "a local area" all performing Cardio-Vascular Surgery should be studied carefully. Where such

areas exist—elimination of too many of these duplication of Heart Hospitals should take place (there is no need for many hospitals to have a Cardio-Vascular "Team" except as an EGO situation/prestige of needless monies being spent).

(4) Doctors, Dental Practitioners, Para-Medics, etc., should be hired on a full time basis (no outside practice allowed" to provide "proper care."

(5) The government shall make grants some Five Billion Dollars for research on Cancer, Diabetes, Heart, Parkinsons, etc., etc. If the United States can send men to the Moon, then surely we can spend money to save lives.

(6) Elimination of "red tape" in getting Medical and Dental treatment. Set up "guidelines" but keep the Goddamn red tape to a minimum. Use of the Social Security card would and should be the ideal solution.

(7) Set up a national insurance program with moderate costs. Perhaps a national lottery with the money really going into this insurance fund might be a possibility.

I comment that I have attached an eight page brochure telling about my son, who has a Heart condition, and I mention that he has had Closed Heart Surgery and Open Heart Surgery and my wife and I don't know how long he will live. Also—the medical world doesn't know what causes his Heart problem.

I request that Congress establish a National Physically Handicapped Children's Program. Every child born with a Congenital Birth Defect should be automatically placed onto such a program; every child should be placed onto this program regardless of the income or assets of its parents; every child should remain on this program as long as they need medical and/or dental care, regardless of the age in life of the sick person.

I comment that I am willing to help your committee or such a "department" at any time any way I can. Pages six and seven of this brochure contain my personal comments about my son's condition and his future.

I had only recovered some months previously from a mental breakdown; a condition brought on by my son's illness. With help from a competent psychiatrist I regained my mental health this past spring: but it is only now, in November, that I am able to return to work.

Members of Congress—I implore you to consider the feasibility of including in the Health Bill a department called: The National Physically Handicapped Children's Program. Any baby born with a Congenital Birth Defect should be AUTOMATICALLY placed onto this program, regardless of the "income" or the "assets" of the baby's parents.

Furthermore—each and every child born with a Congenital Birth Defect should be registered onto this National Physically Handicapped Children's Program by "The Hospital" where the baby is born, at the time of the baby's birth.

Any child with a Congenital Birth Defect not only should be automatically placed on this program but the child should be allowed to go to any hospital in the United States to get the best medical care possible. Not like now, in 1975, in New York State (and many other states)—where "state law" prevents some parents from getting proper medical care because the state is trying to keep their local hospitals filled. In fact—many states don't even have a Physically Handicapped Children's Program, at all.

New York State has 23 approved Cardiac hospitals. St. Francis Hospital, Roslyn, N.Y. is one of these; and it was here that Seth had his closed heart operation, at the age of two months, and it was here that he was scheduled to have his Open Heart Surgery performed. This hospital's "fatality rate" for 1973 was so bad the administrator wouldn't even release it for publication; in 1974, St. Francis's "fatality rate" was 10% (the worse acceptable rate deemed proper for a heart hospital). Quite frankly, St. Francis Hospital doesn't perform enough Open Heart Operation each year so their surgical teams get the proper training.

But was Seth Hoffman allowed by the State of N.Y. to go to Dr. Cooley in Texas? The answer was no! Well, the Hoffmans said to N.Y. State: "to hell with your program!", we're going to Dr. Cooley. And the "medical costs for surgeons and hospital" came to under $30,000.00; about 50% less than the costs would have been in any of the 23 approved NYState Cardiac Hospitals. Besides—not one hospital outside Houston, Texas can boast of having a Cardio-Vascular Surgeon on its staff who has performed over 10,000 open heart operations. Dr. Denton Cooley, of the Texas Heart Institute, performed his 10,000th. open heart operation in 1972.

The story about the ordeal my wife and I went through was not "embellished" in any way by the reporter. Every word told it "like it was"!

It is my feeling that a family shouldn't have to spend their life's savings when a "catastrophic illness" hits some one member (of that family). And "the general public" doesn't realize, also, that many times other members of the immediate family can become "ill" due to the patient's illness.

Unfortunately—most of you cannot relate to the experiences my family went through; or the experiences that many other individuals and organizations are testifying to, at these hearings!

Yes, you can be extremely sympathetic. You can be understanding. You can feel empathy. But—you cannot relate to me, my emotions, my frustrations, my nightmares, unless you, yourself—live through such a nightmare as I have.

When drawing up a Health Bill, I hope you will give consideration to my proposed National Physically Handicapped Children's Program. Information (about this proposed program) should be disseminated to every pediatrician's office throughout the United States. In addition—information should be disseminated by every public library and by every kindergarden teacher in the country.

Good medical health and good medical treatment should not be a luxury for the rich, nor should it cause families to spend any and all the money they have in the world, but rather—it should be available to EVERY citizen of these great United States as a given right.

The cost for such a program as I propose would not be exorbitant, as compared to what it costs the county, state and federal governments now—not to have such a program. I am paying over $600.00 a year, now, for Blue Cross and Blue Shield premiums. And half of my medical expenses are not even covered by Blue Cross and Blue Shield. Unless something is done soon I will not even be able to afford to pay their premiums because their increases keep going up a "——— of a lot faster" than the "cost of living index rate."

It should be noted that I indicate that my proposed National Physically Handicapped Children's Program should be geared to new born babies. I would settle for even that much. If this was done—my family and my son won't gain "one cent" from such a program; and I would be satisfied. But—I hope that your committee will consider the existing thousands and thousands of sick children throughout the United States to be eligible for such a program as I propose.

At this time I am fortunate to now have major medical insurance for my family and Seth. And YOU have insurance for your families. BUT what about all those tens of thousands of families who don't?

I truly hope that you'll read my appended eight page "informational brochure." The March, 1975, article ends with the comment that my wife and I are available if any families with a "heart baby" wished to call or write. Even now, over six months later—we occasionally get a stray letter or phone call. And today, I say to all of you: "If you do consider the feasability of establishing a National Physically Handicapped Children's Program, I will make myself available to be of help (or to lend my support in any way I can) to your committee or whatever Department works on such a program."

By the way—you might like to know that my wife and I don't know how long our baby son will live. He may live one year, five years, fifty years! His condition, Transposition of the Great Vessels (Reversed Arteries), is the second worse "heart problem," and as an illness (it) has not "track record." Twenty years from now—Seth Adam Hoffman will be "a part of the statistics" that will enable doctors to quote to future families "at that time." Now—with our son, we can only be optimistic.

Thank you for allowing me to come here today.

LI
Newsday's Magazine
for Long Island
March 16, 1975
HOW HEART SURGERY SAVED THIS CHILD
Page 4
THE TOTAL FITNESS EXERCISE PROGRAM
SPECIAL PASSOVER RECIPES SECTION

Charles and Anita Hoffman with their children, 5-year-old Marni and 2-year-old Seth.

How Seth Was Saved

Nature goofed badly with Seth Hoffman's heart. Saving his life took the skills of the country's best heart surgeon and the strength and perserverance of the 2-year-old's parents.

By John Pascal
Photo by John H. Cornell Jr.

Seth Hoffman, having just celebrated his second birthday and possessing a vocabulary of maybe 20 words, has no comment on the patches in his heart. What can a 2-year-old kid know about patches anyway? He doesn't even know he has a heart. But he will learn all about it some day. He will learn that he is a medical rarity. They'll tell him about the great slashes in his chest and the needles in his arms, of the desperate trip to Houston that saved his life, of the novel burden he placed on his parents who needed to follow an impossible edict during Seth's first year: Don't let the baby cry. Inevitably, they'll tell him that he once died.

What he can never know, of course, is the savage strain that his parents, Charles and Anita Hoffman of Islip Terrace, suffered during the prolonged siege against Seth's young life, the hellish despair, the rages, the torturous fatigue, the emotional drain, the forlorn hopes for Seth's survival, the endless search for deliverance from the strange anomaly and its ancillary complications that seemed, from the day of his birth, to ordain his death. Nature goofed badly with Seth's heart. It endowed him with a disorder called transposition of the great vessels. Crudely stated, Seth's heart was on backwards when he was born. And later a killer complication developed called pulmonary stenosis that blocked the flow of his already exhausted blood to his fragile heart. Usually both afflictions are fatal. Statistically, Seth today should be dead.

But instead he is alive and reasonably well and was, the other day, godawfully rambunctious as he scooted around the floor, backhanding a big rubber ball and brutalizing a stuffed giraffe and bellowing his wants until his daily 3 PM grouch set in and his mother whisked him to his crib where he dropped off to sleep after a good 10 minutes of lusty, cranky bawling.

But that is progress. He can, at last, cry, and the private hells of Charles and Anita Hoffman are, to a large extent, behind them. Seth is, finally, normal—or almost. He lost nearly a year of development and consequently is small for his age; he weighed 20 pounds on his second birthday. He will be smaller than average for the rest of his life. He was slow to talk and slow to walk, unable to take his first unaided step until the age of 23 months. But the prognosis is optimistic. He will be able to lead a comparatively normal life. No strenuous activity, ever. No football. No gymnastics. Nothing to strain his respiratory system. But otherwise, okay. And behind his recovery lies a remarkable story of courage and perseverence against the most punishing odds. The Hoffmans, Charles and Anita, both in their 30s, are only now beginning to emerge from the trauma that dogged them so relentlessly for so long. They can begin to speak of it, as they did the other day, pulling together a narrative of crisis upon crisis, physical, mental, emotional. It began, they were saying, the day of Seth's birth.

Seth was born at 11:30 AM on Feb. 15, 1973, in Southside Hospital, Bay Shore. It was a term birth, normal delivery. At mid-afternoon, Mrs. Hoffman asked to see her son. No, said a nurse, she needed more rest. By evening, Mrs. Hoffman became concerned. Why, she wondered, wouldn't they bring her the baby? By 10:30 at night, she was demanding an answer and was finally allowed into the nursery. "They told me he was in an incubator," Mrs. Hoffman recalls. "I got very alarmed. Seth was a beautiful baby, seven pounds. What's a seven-pound baby doing in an incubator? They took me to the incubator and I couldn't believe what I saw. Seth was blue. A navy blue. No, worse than that. To me, he was practically black, like a piece of coal."

When blood is low in oxygen, for whatever reason, it becomes a dark bluish red and the skin takes on a bluish tinge. The condition is called cyanosis. On his first day of life, Seth had become severely cyanotic. But as he lay in the Southside incubator that night, no one knew why.

On the following day, the Hoffmans' pediatrician, Dr. David Brodey, consulted with Dr. Thomas McLaughlin of Babylon, a pediatric cardiologist and a senior staff member at St. Francis Hospital in Roslyn, one of Long Island's pioneer hospitals in open-heart surgery. After examining Seth, McLaughlin met with Charles Hoffman in the corridor outside the nursery. "I asked him what the trouble was," says Hoffman, "but he couldn't tell without more tests. His opinion—it was only an opinion—was that Seth had a heart blockage. But I knew it was something terrible because Dr. McLaughlin said it was vital to move Seth to St. Francis where they had the kind of sophisticated heart equipment needed for the tests. If Seth stayed in Southside, Dr. McLaughlin told me, Seth would die."

On the morning of the 17th, Seth was transferred by ambulance from Bay Shore to Roslyn. An incubator kept him breathing. The cyanosis was still severe. "We alerted the police in Nassau and Suffolk," Hoffman says, "and they accompanied the ambulance. It had snowed the night before and the roads were slippery. The police escorted us the whole way, just in case there was an accident."

At St. Francis, Seth underwent X-ray examinations, blood tests, an electrocardiograph and a particularly delicate procedure called catheterization in which a long thin tube was inserted into a vein and threaded carefully into Seth's heart for an X-ray view of the interior. Together, they told the dread story of Seth's life-endangering disorder: transposition of the great vessels.

In Seth, the two great arteries of the heart, the aorta and the pulmonary, were reversed. In the normal heart, the pulmonary artery is attached to the right ventricle and the aorta to the left. Blood that has already circuited the body enters the right ventricle and is carried by the pulmonary to the lungs for a fresh supply of oxygen. The blood then enters the left ventricle and is pumped through the aorta back to the body where it deposits most of its oxygen in the body's tissues. The exhausted blood then returns to the right ventricle where the pulmonary carries it to the lungs for new oxygen, and the life-sustaining cycle begins again. In Seth's case, the arteries were connected to the wrong chambers. The oxygen-poor blood returning to the right ventricle was flowing not into the pulmonary but into the aorta and back into the body. And the oxygen-rich blood, instead of circulating, was being pumped needlessly back and forth between the lungs.

Transposition is one of the rarest and surely one of the cruelest afflictions among infants. Until a dozen or so years ago, a child born with transposition was doomed to die, usually within a couple of weeks. The procedures to correct it

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John Pascal writes Newsday's Long Island Diary column.

'Above all, Charles and Anita Hoffman were told, don't let the baby cry.'

simply had not been developed. Even five years ago, it could be corrected only through an awkward and dangerous two-stage procedure. First, a surgeon needed literally to create a second defect in the infant's heart. Later, when the child was strong enough—at least two and a half years old—massive surgery could be attempted for total correction. As it was, Seth, age two days, was dying, and something drastic needed to be done.

"I didn't know what and I didn't care what," says Mrs. Hoffman. "I wanted my baby to live. When they told me he had transposition and explained what it was I went into shock. It was like somebody dropped an atom bomb on my head. Charles felt the same way I did. 'Do what you have to,' we told the doctors. 'Save our baby's life.'"

On March 1—Seth was 2 weeks old—Dr. McLaughlin performed the first-stage operation on Seth. "They did a ballooning on him," says Charles Hoffman. The procedure is technically called a septostomy. It is an extraordinarily delicate operation. A catheter is run through a vein to the innermost chambers of the heart. At the tip of the catheter is a deflated balloon. Once inside the heart, the balloon is inflated and yanked, ripping a hole in the septum dividing the heart chambers and allowing the oxygenated and the depleted blood to intermingle. It is a palliative procedure and purely temporary, but the blood transiting the body has at least some fresh oxygen in it and it will, with luck, sustain the child until he is old enough for major corrective surgery.

Seth returned home after five weeks in St. Francis. "He was okay for the first three or four days," says Mrs. Hoffman. "Then things started to go wrong. He stopped eating. He wouldn't sleep. He was up 24 hours a day. He wasn't responding. We took him to the pediatrician. We tried new formulas. We tried rescheduling his feeding and sleeping. We tried tranquilizers on him. Nothing did any good. So we took him back to Dr. McLaughlin. Something was terribly wrong. Dr. McLaughlin did another ECG [electrocardiogram] on him and it showed his rhythm, the heartbeat, was very bad. We'd have to take him back to St. Francis for more testing."

Seth re-entered St. Francis on April 15. "He was catheterized," says the father, "and they found that the hole in his heart had closed. That's why he was crying all the time and couldn't eat and couldn't sleep. He was in constant pain. He wasn't getting enough oxygen in his blood and we were right back where we started the day he was born."

A second ballooning was considered too dangerous. What needed to be done was to enlarge the original hole, fold the edges back and sew them firmly into a permanent hem. And that could only be done by cutting into the chest and exposing the tiny heart to the surgeon's hands. It is called closed-heart surgery, but that is a misnomer. The heart is indeed nakedly open. But the surgeon does not have to make a large opening to repair the defect. He may reach it through a small incision and correct it by touch rather than by direct vision.

What differentiates "closed-heart" surgery from much more radical open-heart surgery is that in open-heart, the heart can be detached from its supporting systems. A remarkably sophisticated piece of equipment called the cardiopulmonary bypass machine, sometimes called a pump-oxygenator or a heart-lung machine, supplies oxygen to the blood and pumps it through the body, functioning, in effect, as both heart and lungs. The bypass machine allows the surgeon to strike deeply into the heart's core, gives him an unobstructed view of the heart, and permits him to work for five or more hours while the heart is relatively bloodless. With the bypass machine, the surgeon can remove the heart and replace it.

But Seth was far too young and weak then for open-heart surgery, so the hole in his heart was enlarged in a closed-heart procedure and he was sent home. But with a very special caveat. Seth's heart was frail, imperfect, threatened. It would require the most delicate kind of care. Seth must never be exposed to anyone with a cold; a respiratory infection could weaken the heart. His movements must be kept to a minimum.

Above all, Charles and Anita Hoffman were told, don't let the baby cry. If he cried, the strain on his heart might kill him. If he started to cry, he would have to be picked up and comforted. It would doubtlessly spoil him. He might become intolerably demanding. But he would live.

"We took Seth home about the middle of May," says Mrs. Hoffman. "Right around Mother's Day. We had him home all the rest of the spring and through the summer and into the fall. And all that time we couldn't let him cry. Do you know what it is to keep a baby from crying? That's how they communicate. They can't talk. If they're unhappy or hungry or wet, they cry. That's the only way they can express themselves. Well let me tell you, we went through hell."

"Worse than hell," says the father. Hoffman runs his own printing and advertising business. His office had been in Lindenhurst. But with Seth's return from St. Francis, Hoffman, conscious of the terrible demands Seth would be placing on Mrs. Hoffman, converted his garage and moved his business to his home. "Almost from the beginning," he says, "there was never any relief. Seth was weak and seemed to be distressed all the time. He was on digitalis and in his crib we had him on a Maximist machine, a plastic mask that fitted over his face and forced cold air into his lungs to help them expand. And I suppose the cut on his chest where the doctor went in for the closed-heart operation, and the bandage and everything, all bothered him and he'd cry. Then Anita would rush in and pick him up and cradle him in her arms and walk him and try to quiet him down, or I'd do it, and it seems that's all we ever did, morning, noon, night.

"Both of us were wound up all the time, constantly on the go. There was one five-day period when Seth never slept. We were up five days and five nights, and I remember one day I would not sit down. I was afraid to. I thought that if I sat down even for a minute, I'd never get up again. But that's physical. It's fatigue. It's nerves. Somehow you manage. What was impossible to cope with was the psychological strain, not knowing in the morning if your son would make it through the day or die."

The crisis atmosphere at home had an unforseen effect on the Hoffman's other child, a beautiful and rather shy young daughter named Marni. She is 5 years old and attends kindergarten at the Connetquot Elementary School. "Before Seth was born," says Mrs. Hoffman, "we told her she was going to have a little sister or brother and she was very excited at the prospect and very happy. When Seth came home, she was beautiful toward him and bragged to everyone, even strangers, saying 'that's my baby.' But with all the attention we had to constantly give Seth I guess we ignored Marni. We tried not to. We tried to reassure her every day how much we loved her. But she could see that Seth was getting so much more attention and she pulled into herself. She cried a lot. She regressed in her toilet training. And she'd say nobody loved her anymore.

"She'd sneak out of the house without saying goodbye. And once she did a terrifying thing. She just wandered down the street at 8 o'clock one morning in nothing but her nightgown. She was going to her friend's house. At least they loved her there. It was painful. After that, we made special efforts to demonstrate our love. And I think now that that particular problem is over."

Seth's problem remained, however, and, worse, deepened. "The same problem all over again," says Mrs. Hoffman. "Fitful sleeping, poor eating, and the more time went by, the worse he became. And his blood became thicker. We didn't know why. The closed-heart surgery was a success. The hole in the septum was staying open. He should have been getting oxygenated blood. We knew we'd have to take him in for major surgery later in his life. But that wouldn't be for at least another year and longer if possible. The bigger and stronger the child, the better the chances for success. So we weren't planning on any further surgery until Seth was at least two and a half.

"And yet we knew he wasn't developing as he should have been, and very frankly the thought of living the way we were, constantly on guard, constantly afraid, constantly rushing into Seth at the first whimper of a cry—well, we couldn't go on like that much longer. We were desperate."

Sometime in October, Mrs. Hoffman happened to read in a midwest journal called Grit of a successful open-heart operation at the Yale Medical Center on a three-month-old infant. "My spirits soared," says Mrs. Hoffman. "It was the first inkling I had that just maybe something could be done for Seth."

The Hoffmans discussed the possibilities. "We finally decided," says Hoffman, "that we'd go to the very best." That meant, in America, the most celebrated. And by far, the most famous of heart surgeons in the land, subjects of books and countless newspaper and magazine articles, were the two titans of Houston's world-renowned cardiological complex, Dr. Michael DeBakey and his onetime disciple and later bitter rival, the matchlessly perfect technician, Dr. Denton Cooley.

"So I wrote to both of them," says Mrs. Hoffman. "It was maybe the wrong thing to do. The thought occurred to Charles and I that maybe both surgeons would want to see Seth. And that would be a problem. But we wanted something done now. If they both took Seth's case, we'd handle that later."

Responses came quickly from both eminent surgeons. Within a week DeBakey, the cantankerous genius who once glared from the cover of Time magazine, phoned the Hoffmans and said that though he would examine Seth's records and consult with the Hoffman's personally if they brought Seth to Houston, he no longer performed pediatric heart surgery. "It was a disappointment," says Mrs. Hoffman. "We hoped he'd operate. Still, it was something, and we decided we'd go see DeBakey if we didn't hear from Cooley."

Even more than DeBakey, now 66, Denton Cooley, 12 years younger, is generally regarded as the pre-eminent heart surgeon in the United States. He is an inexhaustible worker, often performing as many as eight major open-heart operations a day. He has done perhaps a dozen human heart transplants and in 1969 implanted the first artificial heart. His reputation rests on the purity of his technique. Heart surgeons from all over the world have traveled to

Turn to page 37

‘If we didn’t have the surgery done now, Seth would be dead in 10 weeks.’

How Seth Was Saved

From page 6

Houston to witness his quickness, his procedural virtuosity. And two days after DeBakey's phone call to the Hoffmans, Cooley, intrigued by Seth's case, wrote to say he not only wanted to see Seth but that he had set up an appointment for the morning of Saturday, Dec. 1, at St. Luke's Hospital in Houston.

With Seth, Mrs. Hoffman flew to Houston where an assistant on Cooley's staff ran Seth through the ritual plethora of tests, including another catheterization to determine the severity of the transposition. “It was a man named Dr. Williams,” says Mrs. Hoffman. “He came out after the tests and told me the transposition problem had been handled well. The septal defect [the hole in Seth's heart] was perfectly adequate. He could live with it for at least another couple of years until the more radical open-heart surgery could be done on him. But that wasn't what was thickening Seth's blood or causing him pain or making him so difficult to live with. There was a more immediate problem. The bottom of Seth's pulomonary artery was closing. Less and less blood was moving through the pulmonary into the lungs. The condition was called pulmonary stenosis. It would have to be repaired right away. We couldn't delay. It was an emergency. If we didn't have the surgery done now Seth would be dead in 10 weeks.

“I said,‘Do it.’ He said the chances weren't too good, maybe 30 per cent survival for a lot of reasons. This was a brand new complication on top of the transposition. Seth's health was poor. And he was so young. I wanted to scream. My boy was going to die anyway. But all I said was ‘do it’ and I went to the telephone and called Charles and told him about it and he said ‘Good God, I hope you told them to go ahead’ and I said I did and he said he'd catch the next plane down and he did. And that was the real problem. He could have lived with the transposition. But the stenosis was killing him. I was in a state of shock.”

The diagnosis was made on Saturday. Cooley operated the following Wednesday. The procedure for correcting pulmonary stenosis is complicated, but in essence what Cooley did was remove the human tissue clogging the artery and replace it with a Dacron patch steeped in Seth's own blood to reduce the possibility of rejection. Dacron was chosen because it is essentially an inert material least likely to provoke the onrush of antibodies the human system produces to reject alien matter. Dipping the Dacron into Seth's blood was an additional precaution aimed at fooling the body, in a sense, into believing it was receiving its own tissue. In any event, the graft worked and Cooley turned to the major defect, the transposed pulmonary artery and aorta.

Since it was physiologically impossible to rearrange the two arteries, Cooley did the next best thing: He rerouted the flow of blood. By using a graft made of the membraneous sac around Seth's own heart, Cooley blocked off the existing channels and created new ones that reversed the two separate flows of blood, the oxygen-poor and the oxygen-rich, into the anatomically wrong heart chambers. The depleted blood now pulsed into the left, not the right, ventricle, picked up oxygen in the lungs and exited by way of the aorta into the circulatory system from the right, not the left ventricle. The procedure was first performed in the late 1960s in Toronto and thus there is no history of its long-term efficacy. Ultimately, Seth may require additional surgery. The membraneous patch may hold as Seth grows older and it may not. But there is no danger for Seth in the immediate future and Cooley feels that there will be no need for a re-evaluation until Seth is about 10 years old.

“It was a miracle of surgery,” says Mrs. Hoffman. “Seth was nine and a half months old and he was the youngest child ever to survive that kind of double operation. We were told later that Seth actually died on the table when his heart stopped and they had to revive it with electric shock. And after the operation he developed a severe case of pneumonia that again almost killed him. There was really very little hope that he'd recover. I remember going in to see him and touching him. He was as cold as ice. But he came through and we took him home Dec. 25. There were lots of medicines he had to take, and tranquilizers. We kept him on a portable respirator for three months. But he made it. That's the miracle. He made it.”

The toll on the Hoffmans during Seth's illness was incalculable. The financial drain alone has been enormous. Excluding air fare, hotel bills and a hundred other minor expenses that inescapably arise during a prolonged illness, the cost thus far has been $26,700. Hoffman's Blue Cross, Blue Shield and major medical have absorbed much of it, but because he changed medical plans during Seth's infirmity, some of his coverage is in dispute and he still owes $11,500 that he may have to pay out of his own pocket.

Moreover, in the aftermath of Seth's recovery Hoffman plunged into a depression so severe that he was unable to continue working. Mrs. Hoffman regained her normal composure. Her husband said, “It was a delayed reaction. I used to be a meticulous worker, a hard worker. But in October, months after Seth came home, I found I couldn't bring myself to walk through the door to the office. I'd get up and throw on an old pair of slacks or something and look at the office and turn away.”

That month, he says, “I just walked away for five days. It happened on a Friday night. I flew down to Curacao and Aruba by myself and sat on the beach trying to pull myself together.”

When he returned, he went into psychotherapy to find some release from the tensions that had been building for a year and a half. “And it's only now,” he was saying the other day, “that the analyst and I agree that I'm ready to pick up my life again.

“But I'd like to say this. No family should have to go through what we did alone. The emotional strain is terrible and doctors don't have the time to spend hours, if necessary, talking to you and trying to overcome your fears. But people with common problems can help each other tremendously just by talking to one another and I want to tell anyone at all who has a child with a heart problem to write us or call us up. We live at 12 Rock Road, Islip Terrace, and our phone number is 581-5522. Please print that. We want to help. The worst thing in the world is to go through a crisis alone.”

April 28, 1975

CORRECTIONS TO THE MARCH 16, 1975 NEWSDAY ARTICLE WHICH
PERTAINS TO SETH ADAM HOFFMAN

The following comments have been made by Charles Hoffman (Seth's father). Notes were made by Charles on April 28, 1975, only to clear up a couple of the inaccuracies that have accured in this excellently written article.

A) Not one person in the Hoffman family (including Seth) received one penny (that means no money) from NEWSDAY for the article that was printed. Yes, we could have used the money to pay some of Seth's bills, but that was not the purpose of the article.

B) In the beginning of the article - a person might get the opinion that our pediatrician, Dr. David Brodey, of Bay Shore, New York, was not on "his day off" , the day Seth was born. Since Dr. Brodey was "off" that day - another pediatrician covered for him. This pediatrician ignored medical procedure by not advising the Obstetrician that Seth was sick; he didn't even visit the mother to tell her that her baby was alive (but sick) ; or failing either of the previous two comments: he could have called the baby's father to alert the father about the condition of the baby.

This covering pediatrician should have done at least "one of the above three choices". Any pediatrician would normally advise the Obstetrician immediately since Seth's "delivery" was completely normal. This is routine procedure even when a " covering pediatrician " is on duty, and the patient is a complete stranger. BUT - "this" covering pediatrician knew Anita and me; he had been a friend of the Hoffman family for over 15 years. He and his wife were at our engagement party in my mother's house. The name of this "inconsiderate" , "thoughtless " , "non-compassionate" pediatrician: Norman Stillman, MD, of Bay Shore, New York.

C) Contrary to the article on the last page, the Hoffman family DID NOT have any Major Medical coverage. Since the magazine section is the only section of the Sunday NEWSDAY that has paper printed in color and is prepared approximately six to eight weeks before distribution and since reporters in general do not let people they write about "proof read the articles that are written" we could not correct this very important mistake.

D) The only other mistakes in the article were very minor and they pertain strictly to medical terminology. These minor mistakes would not even be noticed by the "average" physician.

E) Although the reporter may have worded the article in "Reporter Phrasiology", there were no embellishments afterwards. Even our closest friends never really knew what Anita and I went through from day to day until they actually read the article.

F) To anyone reading this who has friends or relatives who have a baby or young child with a heart condition: Anita and I will be more than happy to talk with them or answer letters as we still want to be of help to the family.

Don't hesitate, should you wish to call. As to the day of the week to call rather than write, the best time to get either Anita or myself on the telephone is any evening or on Saturday or Sunday at any time.

G) Lastly - the amount of medical expenses mentioned pertain ONLY to Seth. Expenses incurred by the Hoffman family due to Seth's illness are over $ 65,000.00.

June 24, 1975

Anita and Charles have been asked about Seth's FUTURE and below are some details.

FUTURE PROGNOSIS FOR SETH:

A. Seth(taken by Anita), returned to Dr. Cooley, Houston, Texas, June 1974 (last year) for his 6-month checkup, which showed that his arteries, heart, lung and other vital organs are in good shape.

B. His weight on June 24, 1975, was twenty-one pounds (21 lbs.).

C. When his weight reaches 25 pounds, he will have a major checkup in Houston, Texas, (this can be 3 months to a year from now, as he gains weight slowly); this checkup will require a "catherization" (minor heart surgery). A "cardiac catherization" consists of passing a long, narrow, hollow plastic tube into one of the veins (in the groin area) until it reaches one or more chambers of the heart, utilizing dyes and photographing the heart, arteries, lung, etc., with sophisticated electronic camera. Pressure recordings are made through the tube and blood samples are taken from it. It is a procedure that requires "an extremely skilled" physician. It is an important research test that adds to the knowledge of the working of the heart.

D. IF WE CAN BEG OR BORROW THE MONEY - Seth will be taken to Houston, Texas, to Dr. Cooley, for this important checkup.

E. Dr. Cooley's pediatric cardiology staff intimated that there exists a strong possibility that Seth may require the re-doing of the "Mustard Procedure" (Open Heart Surgery) when he reaches 100 pounds (his age at 100 pounds, baring any unforseen complications, would be between 10-14 years of age).

F. Seth's current (new) Pediatric Cardiologist (had been on a "Fellowship" on Dr. Cooley's staff when Seth had his Open Heart Surgery) told us Seth has a slight "heart murmer"--but the Pediatric Cardiologist doesn't think this "heart murmer" is too serious or anything we should worry about, at the present time.

G. There is no guarantee that additional Open Heart Surgery will be necessary at 100 pounds; this re-do of the Open Heart Surgery will be determined if the "patch" in Seth's "heart" is outgrown as Seth's body and organs grow larger.

LIFE EXPECTANCY AND DAILY LIFE ROUTINE:

1. Seth is currently off all "heart medication" now. Daily-he takes a liquid tranquilizer to help keep him from being too cranky; he is on Neo-Mullsoy formula (as he is allergic to Milk); he is allergic to Pencillin; and he is on a low-salt diet.
2. Dr. Cooley's staff told us to treat him like a normal baby in all respects (except to be careful in extreme periods of hot weather).
3. Seth can run and play with the other children as he grows older in the back yard; but, he cannot play or partake in "athletic sports" (so maybe we'll have another Chopin !) .
4. We can let him CRY and not worry about him CRYING (YOU will never know what this means to us now).
5. The doctors cannot tell us how long he will live because the condition he has (Transposition of the Great Vessels - which means: Reversed Arteries), is so rare and there are so few children living that have it who have survived the Open Heart Surgery (which alleviates the problem - you cannot correct reversed arteries) so, therefore, there are no statistics on his life expectancy.
6. The "medical world" does NOT (yet) know what causes "Transposed Arteries".
7. If Seth does require the re-doing of the Open Heart Surgery, he will have tremendously greater chances for the "surgery" to be successful. (Anita was told about a week after the Open Heart Surgery that Dr. Cooley (and his associates) didn't think there was any chance for the surgery to be successful; this is what makes Dr. Denton Cooley so great - he'll operate on what seems to be hopeless patients and many times his surgical skill (and God's help) will bring a hopeless patient through surgery successfully. The doctors told us there was a 30% chance of success, ONLYto give us some hope while we waited for the surgery to take place.
8. Dr. Cooley (and his associates) do not expect the Pulmonary Stenosis (which caused the emergency surgery) to occur again.
9. Anita and I are forced to accept the uncertainty of Seth's life expectancy (which obviously effects us emotionally and mentally). Anita had and has SPASTIC COLITIS continually. I had a "mental breakdown", from which I have just recovered. The future for Anita and myself: optimism - (we have no other choice).

Newsday / THE LONG ISLAND NEWSPAPER
15 CENTS
FRIDAY
JULY 25, 1975

A Child Saved, A High Price

By Amanda Harris

Islip Terrace—On Feb. 15, 1973, Seth Hoffman was born with a heart formed backward. When he was nine months old, on an operating table in Houston, his heart stopped. Now, after delicate and dangerous surgery, Seth looks like any other two-year old. He is susceptible to pneumonia but fine otherwise.

Seth's parents, Charles and Anita Hoffman, are faced with paying the bills. Blue Cross has agreed to pay all * but about $5,000 of the $26,700 total. But Hoffman wants a state and county-funded plan to pay all the hospital expenses since Seth's birth.

Seth's survival has been an ordeal. In his heart, the pulmonary artery and aorta were reversed. Fresh, oxygen-enriched blood pumped back and forth between his lungs, while oxygen-poor blood was sent to replenish his body tissue.

When he was two weeks old, a specialist at St. Francis Hospital in Roslyn performed closed-heart surgery to repair the potentially fatal disorder. The operation was an initial success, but when Seth was nine months old, a complication called pulmonary stenosis set in: Less and less blood began traveling through the pulmonary artery to the lungs. When this new condition developed, Seth's parents took him to the famed Texas Heart Institute in Houston for diagnosis. He was given 10 weeks to live.

His parents ordered the necessary operation, and Dr. Denton Cooley, world-famous heart surgeon, successfully rerouted the path taken by Seth's blood. During the operation, the boy's heart stopped and had to be started again with an electric shock. Except for a bout with pneumonia last month, Seth is doing well, according to his father.

> *'We will take Seth to Texas whenever he needs to go. We will beg, borrow or steal the money, but we will get him to Dr. Cooley.'*
>
> —Charles Hoffman

Hoffman, a self-employed printer and advertising man, also has a healthy five-year-old daughter. In April, 1973, he found out about the Physically Handicapped Children's Program, a plan that offers complete medical coverage to children suffering from congenital diseases if their parents meet specific financial criteria.

But the Hoffmans have not filled out the necessary forms. "I couldn't do it. My psychiatrist says I had a mental block about those forms," Hoffman said. "He said I thought if I sent them in, the baby would die." Hoffman said he has just recovered from a total emotional breakdown caused by the strain of Seth's illness.The family also violated a major rule of the program when they took Seth to an out-of-state doctor.

"We never pay for out-of-state care unless it is preauthorized and it has been clearly established that the same care cannot be gotten in New York," said Dr. Martin Mayer of the Suffolk County Health Department, who runs the program here. Mayer said Hoffman was told before and after the Texas operation that the state would not pay the bills. Twenty-three hospitals in New York, including St. Francis, are authorized to perform the same operation, Mayer said.

Hoffman disagrees. "There are very good surgeons in New York," he said. "But why go to a good man, when you can have a great one?" He and his wife were displeased with the treatment Seth received here; they give Cooley full credit for saving their son's life. "We will take Seth to Texas whenever he needs to go," Hoffman said. "We will beg, borrow or steal the money, but we will get him to Dr. Cooley."

The issue has been turned over to the State Health Department's lawyers, who will decide soon whether Seth can join the program. "We try to do as much as we can for everyone," Mayer said, "but it's like welfare—just because a person says he's qualified, you don't just send him a check . . . Look, we're a bunch of bureaucrats. Sometimes an unusual person is very difficult to handle within the system, because he can't follow the rules. But when you're spending the taxpayers' money, you have to follow the rules."

Newsday Photo by Thomas Koeniges

Marni, 5, plays with her brother, Seth

NOTE: The only mistake in this NEWSDAY article, which is dated Friday, July 25, 1975, is that so far Blue Cross has agreed to pay only about one half of the $26,700,
* NOT the amount of $5,000.

On the advise of his physician on August 15, 1975, Charles Hoffman has given up his fight with the New York State Physically Handicapped Children's Program due to the aggravated mental and health problems, due to the run around by officials of these various Suffolk County and New York State Departments.

Mr. Rostenkowski. Mr. Theobald.

STATEMENT OF GEORGE J. THEOBALD, JR.

Mr. Theobald. Thank you. I am replacing Dr. Louis Aledort, our medical director, and Louis Friedland, our chairman of the board, who is president of MCA–TV.

The foundation has appeared before this committee before, and in our statement we have appended our previous testimony which we would like to be part of the record. I believe all of you know that hemophilia is a genetic bleeding disorder. Thirty percent of the cases are new cases coming from families without any history of the disease. It is the fastest mutating disease that is known. Hemophiliacs are crippled by their own blood. They are both fortunate and unfortunate. They are fortunate because there is a control, the clotting factor, and unfortunately, it is so expensive, and it gives credence, quite frankly, to the misnomer that hemophelia is a disease of royalty, because what you need is access to a king's coffers to pay for it.

It is the most expensive chronic disease in the United States today, and the 1972 National Heart and Lung Institute study, the product cost ranged between $24,000 and $42,000 for 1 year.

Our position is, as we have stated it previously before this committee with regard to national health insurance proposals, that we believe that care coverage is needed for hemophiliacs and all others who suffer from chronic blood disorders. The coverage is also needed for product, for blood, blood products, and blood derivatives, and the coverage should also include inpatient and outpatient care; the outpatient care phase is very important, because our studies now prove that people who are on medically approved programs of home care, the cost of their care goes down rather dramatically.

Dr. Peter Levine, in a study done at the New England Tufts Medical Center, determined the cost was about $5,900 for inpatient care; on approved programs, this dropped to about $3,400.

If the committee wishes, I would be delighted to send to you, for the record, Dr. Levine's record of this study.

Mr. Rostenkowski. Please do that, and we will file that with the committee.

Mr. Theobald. The study also found that hemophiliacs did not lose as much time from school. Before the home programs went into effect, they were losing approximately 10 days a year. Now they are losing much less; only 1 day.

There are other things I would like to bring to the attention of this committee.

One is, because of the economic conditions, those facing the Nation, if any program is to be enacted, we believe it will be catastrophic insurance programs; the Long-Ribicoff approach now calls for people who have an income of more than $4,800 a year, that they would be responsible for the first $2,000 of medical care, and 60 days of care, after which catastrophic benefits would begin.

This kind of program, if it does not have an exception for those suffering from chronic illnesses, would be catastrophic to the hemophiliacs and we believe to many others who suffer from chronic diseases.

We believe that if you should opt for a catastrophic plan, you should address this provision in a new way, and I would like to offer some suggestions.

One is that those with chronic illnesses be so certified by physicians so that after the first year of their illness, they would not have any deductibles to pay for their chronic disease. Second, that licensed insurance companies insure persons up to the first $2,000 of medical care and for the first 60 days of hospital care and that they could not discriminate against anyone, especially those with chronic illnesses such as hemophilia.

Third, we think perhaps another approach to catastrophic health insurance might be for those who are disabled with a chronic illness receive a special catastrophic deductible for from, let's say, the $2,000 that has been proposed down to maybe $100.

We believe that there must be a strong provision for home health care. The costs of care can be driven down significantly if care is done at home, and I refer to Dr. Levine's study; there are other studies available.

One last point. We believe that it is important that we, because we represent the largest blood users in the United States today, speak about a blood delivery system; we feel that no national health insurance program can be effective unless the blood delivery system of the United States is looked at very carefully, and integrated into health insurance proposals.

I think that you are aware that the national blood policy, which has been articulated by DHEW, now has a private sector group working to implement it; the American Blood Commission, and we are part of that organization.

I think all of you are aware of the recent actions of the Congress that will effect the blood delivery system.

Congress in July 1975 passed a law—Public Law 93–64—over a Presidential veto. It authorizes, among other things, support for establishment of hemophilia treatment centers, and grant and contract programs to upgrade nonprofit blood separation centers.

Just 3 weeks ago, a House subcommittee agreed to a total of $3 million in appropriations for these programs, and we believe the Senate will do likewise.

Also, the House has passed, and we again believe the Senate will, a bill providing that the word "blood" be added to the National Heart and Lung Institute's title and that a specific mandate be given to the Institute to allow it to do research into blood resources.

Language in the bill report clearly stated the concerns of the House Subcommittee on Public Health and Environment regarding the problems of blood distribution and in blood resources research.

Many Senators and Representatives have indicated to us their desire to begin hearings on the problem of blood and its distribution, and it is quite likely that next year such hearings will be held.

Blood is our most precious natural resource, and we would urge this committee to give it the careful consideration when it considers provisions of national health insurance legislation.

Our medical director, Dr. Louis Aledort, is a member of the advisory panel to this committee regarding national health insurance.

Both Dr. Louis Aledort and myself and the other members of the foundation are available to you to discuss the specifics of hemophilia, to discuss the problems of chronic blood disorders, and more importantly, I think, to discuss with you and give you our knowledge on the whole blood system in the United States.

I thank you for this time.

[The prepared statement follows:]

STATEMENT OF THE NATIONAL HEMOPHILIA FOUNDATION

Mr. Chairman, thank you for giving the National Hemophilia Foundation the opportunity to testify before you regarding National Health Insurance.

Representatives of the Foundation appeared before the committee last year to give our views. A copy of that testimony is attached, and we hope that it can be made part of this hearing record.

Our views are unchanged as to the need for a national health insurance program. We made three major points at that time:

(1) Medical coverage for hemophiliacs and other persons with chronic blood disorders, whether they are in-patients, or on medically approved home care programs, should be covered.

(2) Persons for whom the maintenance of life and health required periodic or systematic transfusions of blood and blood derivatives will be covered for the cost of their blood product, its preparation, and its administration.

(3) Such payments should apply to the use of in-patient and out-patient facilities and under medically approved home care programs.

We would like to make two other major points today.

First, it seems to us that because of the economic conditions now facing the nation, if any program is enacted it is likely to be a catastrophic insurance program.

The Long-Ribicoff bill approach would require that in any given year, a family of four persons having a total income of more than $4800 a year, would be required to pay $2,000 for medical care, and for 60 days of hospital care, before the catastrophic benefits would begin.

This kind of financing program, if it does not have an exception for chronic illnesses, would in fact be catastrophic to families of hemophiliacs. Hemophilia is a chronic illness, and as a consequence—because of the costs involved for care—there is a continual drain upon income, and there would be no chance for a family to accumulate savings; indeed, any savings that could be pulled from income might well take place at the expense of the hemophiliac's health. There would be very little money available to pay those expenses required year after year under a Long-Ribicoff bill.

Therefore, we believe that if you do move to a catastrophic plan, that provision ought to be made for those with chronic illnesses, which might be done in one of two ways: first, that those with chronic illnesses be certified by physicians, and after the first year of family payment for medical and hospital bills, total costs of care would be paid for, or alternatively, that licensed private insurance companies which would insure persons for the first $2,000 of medical care and the first 60 days of hospital care could not discriminate against anyone, for any reason, including previous history of chronic illness.

Second, there should be a very strong provision for home health care. In our previous testimony, we told this committee about the rapid increases in the cost of care for hemophiliacs, and the staggering increases in the costs of whole blood, blood concentrates, and other blood materials. However, we know now, after numerous experiments, that the costs of care can be driven down significantly if the care is done at home. It is clear to us that if provision is made in any national health insurance legislation for home health care, that incentive would be enormously helpful to us in restructuring care patterns and in helping to lower the costs of care without lowering the quality of care.

Also, we believe it is necessary to speak about the blood delivery system in the nation and its relation to national health insurance.

It is clear to everyone who looks at the blood delivery system that it is terribly, and wastefully, fragmented and inadequate. Of course, as hemophiliacs as a group are the greatest users of blood and its components, we have a particular interest in reform of the system. But in fact all persons who need blood at any time would be served by reform.

The committee should be aware of recent actions in the Congress to improve the blood delivery system. First, Congress passed a law over a presidential veto, which authorized a program of support for comprehensive hemophilia treatment centers, and grant and contract programs to upgrade non-profit blood separation centers. Just a week ago the House agreed to a total of $3 million in appropriations for these programs, and it is likely the Senate will do likewise. Also, the House recently passed, and it is likely the Senate will do as well, a bill providing that the National Heart and Lung Institute be changed to the National Heart, Lung, and Blood Institute, and that a specific mandate be given to that Institute to do research in the field of blood resources. Language in the bill report clearly spelled out the concerns of the House Subcommittee on Public Health and Environment regarding the problems of blood distribution and of the opportunities available in blood research.

Many Representatives and Senators have indicated their desire to begin hearings on the problems of blood and its distribution, and it is quite likely that in the next year hearings will be held and legislation passed establishing national blood policy.

The Foundation is pleased that its Medical Director, Dr. Louis Aledort, is a member of the advisory panel to this committee regarding national health insurance. Please call upon him, or any of us at the Foundation, for any help we can give.

Our previous testimony is attached to our remarks, and we would appreciate it being made part of the record. I would be happy to answer any questions you have.

Appendix

TESTIMONY OF APRIL 15, 1975

Mr. Chairman: The National Hemophilia Foundation,[1] as you requested, is pleased to make a statement on the need for a National Health Insurance Program.

Last year, on June 14, two of the leaders of the Foundation [2], testified before the Ways and Means Committee urging the passage of National Health Insurance. They were very pleased at the courtesy shown by the Committee at that time, and were grateful for it.

The situation regarding hemophiliacs in the nation has changed significantly since last year, and the *cost of care* has changed. We all know that the cost index for medical care went up by nearly 15% last year, and we must report that the costs of whole blood, blood concentrates, and other blood materials rose in price even more quickly. In addition, in a stagnant economy where jobs are scarce, the hemophiliac, frequently discriminated against in job seeking anyway, has a still more difficult time finding employment.

The basic situation described in our testimony last year has not changed, nor have our suggestions for inclusion of hemophiliacs under National Health Insurance. You will find our complete testimony from last year on pages 2400–2406, in Volume 5 of the hearings of 1974.

We have excerpted these pages, and made them a part of this testimony, and we would like to have them included in the record of the hearing at the end of those remarks. We call your attention to two specific points in that testimony which have changed:

> On page 2401, lines 9 and 10. The costs of replacement of materials risen from $5 to $30 a unit, to $12 to $40 a unit, or from $2,000 to $5,000 a year last year to $5,000 to $8,000 this year.
>
> On page 2404–3. We comment on the Mills-Kennedy and Long-Ribicoff bills of last year. While these bills are not now specifically being heard by the committee at this time, nevertheless the principles we suggest there have not changed.

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[1] The National Hemophilia Foundation, located at 25 West 39th Street, New York, New York 10018, is a voluntary, non-profit health agency, and the only national organization concerned with the disease of Hemophilia. The Foundation is an active member of the National Health Council, and furnishes reports to the National Information Bureau. It maintains an active liaison with the American National Red Cross and other organizations that are concerned with assuring an adequate sale and reasonably priced supply of blood and blood products to those who require it. The Foundation is also a member of the Ad Hoc Committee to establish an American Blood Commission. For further information, contact Mr. George Theobald, Executive Director.

[2] Margaret W. Hilgartner, M.D., Member, Medical Scientific Advisory Council, and Louis N. Friedland, Chairman of the Board.

We also request that another attachment be made part of the hearing record: this is an excellent comprehensive and systematic analysis of the situation confronting the hemophiliacs of the nation, developed by the National Heart and Lung Institute, in conjunction with the National Hemophilia Foundation and published early in 1975. It will be valuable to the committee for their understanding of the situation.

Of course, we will be pleased to be helpful to you at any time. Please call on us.

[Exhibits appear at this point in the record.]

STATEMENT OF MARGARET W. HILGARTNER, M.D., MEMBER, MEDICAL AND SCIENTIFIC ADVISORY COUNCIL, NATIONAL HEMOPHILIA FOUNDATION, ACCOMPANIED BY LOUIS N. FRIEDLAND, CHAIRMAN OF THE BOARD

Summary

The National Hemophilia Foundation urges that a national health insurance bill include the following provisions:

(1) Medical coverage for hemophiliacs and other persons with chronic blood disorders, whether they are in-patients, out-patients, or on medically approved home care programs.

(2) Persons for whom the maintenance of life and health requires periodic or systematic transfusions of blood and blood derivatives will be covered for the cost of their blood product, its preparation, and its administration.

(3) Such payments should apply to the use of in-patient and out-patient facilities and under medically approved home care programs.

Dr. Hilgartner. I am Margaret W. Hilgartner, M.D., associate professor of pediatrics and director of the hemophilia clinic at the New York Hospital—Cornell Medical Center in New York City.

I am a member of the Medical and Scientific Advisory Council of the National Hemophilia Foundation.

With me is Mr. Louis N. Friedland, president of MCA-TV and the chairman of the board of the National Hemophilia Foundation. Mr. Friedland is the father of a hemophiliac.

I come before you today on behalf of the almost 100,000 hemophiliacs in this country—25,000 of whom are severely or moderately severely affected. I am not here to comment as to the mechanism by which national health insurance is administered nor as to the deductible limits for coverage. I leave that to the expertise of this committee.

We are here today to inform you about the needs of this group of hemophiliacs and others afflicted with chronic diseases requiring continuing use of blood and/or blood products. To ignore the blood needs of this group, the largest single blood consumer in the Nation, would be retrogressive and thus contrary to the conception of a national health bill.

HEMOPHILIA AND ITS TREATMENT

Hemophilia is a genetic disorder of the blood in which a clotting factor is either partially or completely missing. Hemophiliacs are unique among chronic disease victims because they are not born crippled and can be cured if financial conditions allow them to obtain the missing clotting factor. Without this onging treatment, the hemophiliac becomes an unnecessary burden to himself, his family, and to society.

The sufferer is subject to spontaneous hemorrhaging both internally and externally. With the repetition of bleeding episodes, the hemophiliac becomes crippled by his own blood.

A bleeding episode may occur without warning. Consequently, there is a tendency among family members to curb day-to-day activities for the sake of the sufferer.

The psychological toll is incalculable, and in some bases, devastating. Even with optimal genetic counseling, hemophilia has an extraordinary high [illegible]e of occurrence, and I would state flatly that it cannot be eradicated.

The disease may occur spontaneously, without any previous family history, and as such hemophilia has the highest rate of mutation of any genetic disease.

Medical advancements provide us with materials capable of correcting the missing clotting factor. Bleeding can usually be checked with transfusions of fresh whole blood, plasma, or clotting concentrates. This procedure is known as replacement therapy; 25,000 patients are severely enough involved to require continuous replacement from birth to death.

The hemophiliac poses specific medical and financial problems:

1. Replacement material is extremely costly, the average expenditure running from $5 to $30 a unit, or about $2,000 to $5,000 per patient per year.
2. Replacement therapy is generally carried out in an outpatient emergency room where "third party" coverage is often unavailable.
3. Reconstructive surgery for correcting crippled joints is both time-consuming and extraordinarily expensive, and the cost of blood products alone, without doctors' fees or hospital costs, can be as much as $15,000. Again, this is rarely covered by "third party" payments.
4. In the past 10 years, there has been a marked increase in blood product utilization by hemophiliacs and the National Hemophilia Foundation is continuing and furthering its errors in blood donor recruitment.

Recognizing that the increase in blood use could outdistance the supply, we have advocated the concept of "component therapy." This means that a unit of blood is fragmented and its parts distributed according to specific needs.

One type of hemophiliac, for example, needs only a small plasma portion called cryoprecipitate; another hemophiliac is able to utilize the remaining plasma; a leukemic is able to use the platelets derived from the same unit; while another patient, perhaps hospitalized with a bleeding ulcer, might use the red blood cells. One unit of blood, then, has met the needs of four patients.

HOME THERAPY

A hemophiliac can live a useful life as long as replacement therapy is readily available. When it is, hemophiliacs—whether they are students or employed—show a positive attendance record.

But the time spent waiting in hospital emergency rooms is compromising and costly. It is for these reasons that many areas of the country have successfully initiated programs of "home therapy."

At the onset of bleeding, a patient may give himself an infusion of the necessary blood component, which will control both pain and bleeding. This is being carried out at home, at work, and at school. There is no question that "home therapy" provides the most satisfactory treatment for the newly diagnosed hemophiliac, particularly if we believe that the aim of modern medical care is to decrease the need for hospitalization and Government-dependent patients. It is vital therefor that in addition to inpatient coverage, both outpatient and home care programs be covered in national legislation.

SUMMARY

Essentially, we face two problems. One is the rehabilitation of patients already crippled; the second is the long-range management of the newly diagnosed child. Both problems create extensive financial drains on families and communities, setting aside for the moment the emotional strain and social stigma.

The costs of outpatient replacement therapy are still beyond the normal financial capacity of the average family, and many families become medically indigent as a result. This is why coverage of replacement product costs is so desperately needed by hemophiliacs. It is important to realize that even though the initial cost of providing such coverage for outpatient replacement therapy may increase the public burden for the moment, the long-range expense to the taxpayer will be lessened as more and more hemophiliacs are able to maintain their health, become educated, work without great absenteeism, and eliminate the need for public assistance.

Again, I would emphasize that hemophiliacs can become functioning, productive members of our society if they are able to obtain adequate therapy. By a continuous replacement of the missing clotting factor, they are able to become the living dividends of the very investment I am requesting here today.

Therefore, the National Hemophilia Foundation urges that a national health insurance bill include the following provisions:

1. Medical coverage for hemophiliacs and other persons with chronic blood disorders, whether they are inpatients, outpatients, or on medically approved home care programs.
2. Persons for whom the maintenance of life and health requires periodic or systematic transfusions of blood and blood derivatives will be covered for the cost of their blood product, its preparation, and its administration.
3. Such payments should apply to the use of inpatient and outpatient facilities and under medically approved home care programs.

COMMENTS ON SPECIFICS OF LEGISLATION

Mr. Chairman, we now would like to comment upon the specifics of the various bills now before you for consideration.

As you requested, we will confine our remarks to the Mills-Kennedy bill, the Long-Ribicoff bill, and the administration bill.

We request in regard to all legislation proposed, that the payment for products and services be treated at least as well as the payment and services for any other disease. We now comment on the three bills' provisions regarding blood and blood products as used by hemophiliacs.

As we understand it, H.R. 13870, the Mills-Kennedy bill, would probably provide for such care, but we would like to urge that those portions of the bill relating to provision of costs of such care be clarified.

On page 117 of the Mills-Kennedy bill, the terms "drug" and "biologicals" are defined, and as such the blood and blood products used in care of hemophiliacs probably would be covered, but we would like to have that portion of the bill clarified.

We would like to see language in the bill and in the bill report state that for the purposes of this legislation, blood and blood products utilized in the care of hemophiliacs, be considered as prescription drugs.

In addition, on line 9, page 118, we would like to see the phrase "(except for insulin)" which of course refers to diabetics, and which was inserted here to permit nonprescription insulin drugs to be covered, changed to "(except for insulin in the case of diabetics, and blood and blood products in the case of hemophiliacs and other chronic blood disease patients)."

We would like this change because it is clear that advances are occurring rapidly in the treatment of hemophiliacs, and at some time it might well be possible that the blood and blood products used, especially those in home treatment and self-treatment modes, will not require prescriptions, in which case we would like them still to be covered as are the other fully covered prescription drug items.

As to the administration bill, H.R. 12684, we are pleased that blood and blood products are covered as a benefit under the bill.

However, we call to your attention the language of the bill, section 1832(b)(2)(C), line 18, page 30, which states "(C) The plan shall impose, with respect to blood and blood products, such deductible as the Secretary may, by regulation, prescribe."

This is an important section for us, because it is possible that the Secretary might prescribe a higher deductible on blood and blood products than on drugs and biologicals, which is the lower rate of deductible costs, and may make such deductibles as high as "all other items and services other than outpatient drugs and biologicals" as provided on pages 29 and 30 of the bill, beginning on line 19, page 29.

The problem we have with this language is that it does not differentiate between the blood needed by the chronic blood disease patient and the patient who requires blood as the result of surgery, accident, or other event.

We would prefer that blood and blood products which are administered to hemophiliacs, which require a prescription like any other drug or pharmaceutical, be treated as such in the deductible program at the lower of the deductible rates provided.

And finally, in regard to the Long-Ribicoff bill, S. 1376, we believe that language should be inserted to make clear that the blood and blood products used by hemophiliacs are to be treated just as would prescription drugs and pharmaceuticals.

We must say another word about the Long-Ribicoff bill. Clearly, this bill has been written to provide catastrophic protection for persons who might suffer from a nonchronic illness, so that the life savings should not be wiped out.

Hemophilia is a chronic illness, and as a consequence—because of the costs involved for care—there is a continual drain upon income, and there is almost no opportunity for savings: indeed in many cases, any savings that can be pulled from income might well take place at the expense of the hemophiliac's health. Thus, the chronic illness of hemophilia presents a chronic catastrophe to himself and to his family.

Mr. Burleson. We are glad to hear you.

Mr. **Friedland.** Ladies and gentlemen, we do appreciate the opportunity to come here not only on behalf of hemophilia, but all of those to whose needs you are paying attention. I have submitted a written statement and I wonder if I might just amplify some portions of that by demonstrating what we are talking about.

Mr. **Burleson.** Your statement will be included in the record.

Mr. **Friedland.** Mr. Chairman, members of the Ways and Means Committee, ladies and gentlemen, my name is Louis Friedland. I am chairman of the board of the National Hemophilia Foundation. In my less demanding moments, I am president of MCA-TV, associated with Universal Studios of California.

I am here to speak for every father whose son has not as yet escaped the chains of hemophilia as mine has done.

I have participated in a medical miracle.

For the first 17 years of his life, my son lived in massive leather braces on his arms and legs. He rarely attended school. He could barely make it to the bathroom. He hemorrhaged heavily into his joints many times each week. We spent endless nights in the waiting rooms and emergency rooms of hospitals. The braces were never off, day or night.

Most people don't know that in addition to its other hazards, hemophilia wrecks the joints. The bleeding into the joints causes a kind of rusting and rotting which destroys bone and tissue. This internal bleeding brings immense swelling and pressure which causes endless pain beyond your ability to imagine.

Here are the braces Eric wore on legs and arms. He doesn't wear them anymore. We chucked them into the cellar.

For 4½ years, he has given himself a daily infusion—each and every day—of a blood concentrate which supplies what he needs to bleed normally. He infuses himself with a white material, the size of a half sugar cube, in saline solution. He infuses himself every day to prevent injury.

Four years ago, as a result of these self-treatments, Eric left his chains behind, drove 40,000 miles a year—usually straight up. He has traveled all over Europe. He is a student at Harvard. He has a beautiful girlfriend, and he is living. So am I. So is my wife who spent 17 years at his side. So will we all.

Eric's self-infusion cost $70 a day, each and every day; $26,000 a year. I pay for it. Thank God I can do so.

What about all the other kids? Considering that there are varying degrees of severity, the average boy would require about $5,000 a year to avoid crippling and disasters.

The blood concentrates Eric uses are delivered to our home. When Eric first began to give himself the infusions, I had to go to the old hospital to obtain the blood concentrates. I walked through the emergency waiting rooms, and there were the other kids who couldn't afford the treatment Eric was getting, still waiting, joints swollen, and in desperate pain.

There is no way any human being can allow that to continue. I can't.

Many magnificent people have come forward to make possible full care, or partial care, for hemophiliacs.

In a few parts of the country, the care is great. In some places, it's OK. In some places, it's close to zero.

For money, we can deliver normal lives to these kids here and now. And eventually costs will come down.

Moreover, provision of needed concentrates to young hemophiliacs now will make it possible for them to become fully productive members of our society. In this sense, it is a long-term investment which will save us the human agony and public costs involved in dealing later with needlessly disabled human beings.

There is no way we can say to any kid, "You will be crippled, you may even die for want of a dollar bill."

Must we tell him that the Government isn't ready now? That he must wait till next year, or the year after?

We can't say that to any kid.

Thank you.

Mr. BURLESON. Thank you very much for a very dramatic presentation.

Mr. CONABLE. I would like to ask the doctor why a hemophiliac has joint damage. Is it the movement of the joint, something that causes the rupture of a blood vessel, so that it is constantly hemorrhaging?

Dr. HILGARTNER. It is a long progression and early in a person's life he may fall and this initiates the bleeding. With repeated episodes of bleeding the process evolves in which there is an overgrowth of the lining of the joint and this lining of the joint in and of itself bleeds very easily. With the continual bleeding we get the destructive processes in the joint. The picture that Mr. Friedland gave you there shows the enlarged joint after the boy has had several bleeding episodes and we get the chronic case where there is this tremendous enlargement inside the joint of the joint lining. This joint lining, which can bleed so readily, also produces enzymes that attack the cartilage of the joint and after several years the arthritic problems come.

This is the total crippling of the disease.

Mr. CONABLE. Thank you very much. I didn't understand why that should be. I thought perhaps the braces were protection against cutting.

Dr. HILGARTNER. No, protection against movement and against falling and to allow the joint to heal.

Mr. CONABLE. Is there a heredity factor involved? I know there have been royal families in the past that have suffered from hemophilia, indicating there is some hereditary factor involved.

Dr. HILGARTNER. Yes, there is. The gene which apparently causes the disease is carried through the mother and is expressed in the boy. But unfortunately, as I stated here, we cannot control the expression of this disease, even with good genetics counseling, because there is such a tremendous mutation rate of this gene. We find every year 25 percent of our new cases with no family history whatsoever, so that the mutation rate of this particular gene is extremely high.

Mr. CONABLE. It is carried through the mother, but affects only the male?

Dr. HILGARTNER. That is correct.

Mr. CONABLE. That is a very odd disease. Thank you very much.

Mr. BURLESON. Dr. Hilgartner, how many hemophiliacs are there?

Dr. HILGARTNER. We have 100,000, of which 25,000 have a severe disease and require fairly frequent transfusions. Each of those

25.000—and I get these statistics from the NHLI report which was just published in 1972 and is really the only source for good statistics—about half of those severely involved patients require transfusions over a 2-year period.

Mr. Burleson. Thank you both. You have made a very fine contribution.

Mr. ROSTENKOWSKI. Do you think national health insurance should cover the special freezers needed at home?

Mr. THEOBALD. Would you repeat that?

Mr. ROSTENKOWSKI. Do you think that national health insurance should also cover the special freezers which are needed if the blood factor is kept at home?

Mr. THEOBALD. This may or may not be part of it, but quite frankly, I think the research that is going on now will indicate that there are products where you do not need, really, the frozen plasma. What you need is the concentrate which can be mixed with sterile water.

If you are going to make a hemophiliac a tax-paying member of this society, you have to give him benefit of making use of the concentrate so he can live a full life. If he does not have it, he is going to be crippled.

Mr. ROSTENKOWSKI. Dr. Goldensohn, in your professional capacity as a urologist, what is your knowledge of the effects on his life of the medical expenses incurred by a person with epilepsy?

Dr. GOLDENSOHN. Mr. Chairman, they are tremendously profound.

Perhaps I could tell you something that happened last week, because I think it applies to the national health insurance program in that regard.

I mentioned in my formal report the computerized X-ray technique which is very, very helpful in the diagnosis and treatment of the patient with seizures.

That examination now as an outpatient, someone who is not in the hospital, costs the individual at our hospital $265 for that special X-ray examination.

He is completely unable to pay it. There is no way. If he happens to be that half, that 50 percent, that has some health insurance, some commercial insurance, he might be able to go to the hospital under the Blue Cross. There, the Blue Cross will pay for part of that, or most of it, and he will occupy a bed. The most uneconomical way of treating patients is that way.

So, Mr. Chairman, I think when you set up this program, as was mentioned by the other speakers, the treatment at home, the treatment as an outpatient should be covered just as the treatment of an inpatient should, so that this tremendous problem, this impossible burden on the epileptic patient can be handled, and he can be treated and get back into society.

Mr. ROSTENKOWSKI. Thank you, Dr. Goldensohn. Mr. Cotter will inquire.

Mr. COTTER [presiding]. Thank you very much.

Dr. Goldensohn, you mentioned about outpatient testing. Do you have any figures of what savings could be accomplished by following this procedure, rather than testing in hospitals?

Dr. GOLDENSOHN. It would be a tremendously—a tremendous saving. Just an off-the-cuff savings, if the patient required 3 days in the hospital to do these outpatient tests, all of them that are necessary, the bed costs in New York City run over $200 a day.

Mr. COTTER. And it could be done as satisfactorily in a doctor's office?

Dr. GOLDENSOHN. Or in the laboratory at the hospital without entering the hospital and occupying a bed.

Mr. Cotter. Which is leading up to my next question, which I have jotted down here. How often do you repeat these tests? It has to be done periodically?

Dr. Goldensohn. Yes. Being that epilepsy is a symptom of many causes and many diseases, the tests have to be repeated to make sure that you are not dealing with a progressive disorder that has to be handled in some special way. Probably, because the patient requires medication for the rest of his life, one must be sure that he had adequate amounts in his blood. This can only be done by very special techniques, and that he is not toxic from it, and having symptoms that you do not recognize as being related to the drugs. So the patient must be seen at intervals and these tests done at intervals.

Mr. Cotter. Thank you very much.

Dr. Hamilton, you mentioned in your testimony that it was important to start rehabilitation services early.

Could you give us an example, or elaborate on that?

Dr. Hamilton. I think perhaps the best example of early intervention with rehabilitation in the care of the spinal cord injured. When early occupational therapy, and early physical therapy is provided within the first 20 to 30 days, as it is in the regional spinal cord injury care systems currently in existence, we find we can shorten the hospital stay 25 to 30 percent.

The concomitant savings in dollars is at the rate of approximately $150 to $175 per day.

Mr. Cotter. Does it also result in more success with the services and rehabilitation services?

Dr. Hamilton. Yes. There are fewer complications such as skin contact ulcer, and urinary tract infection and others.

Mr. Cotter. Thank you very much. I have no further questions. Do any of you care to comment or discuss your testimony with anyone else on the panel?

If not, I appreciate you all being here, and the committee will stand adjourned until 1 tomorrow afternoon. Thank you, gentlemen.

[Whereupon, at 2 p.m., the subcommittee adjourned, to reconvene at 1 p.m., Tuesday, November 18, 1975.]

NATIONAL HEALTH INSURANCE

TUESDAY, NOVEMBER 18, 1975

U.S. House of Representatives,
Subcommittee on Health,
Committee on Ways and Means,
Washington, D.C.

The subcommittee met, at 1:10 p.m., pursuant to notice, in the committee hearing room, Longworth House Office Building, Hon. William R. Cotter presiding.

Mr. Cotter. Thank you very much, gentlemen. The subcommittee will come to order.

Chairman Rostenkowski asked me to apologize. He has been held up in another meeting and should be here shortly.

The procedure which we have been following is to have each member of the panel testify and, following that, there can be an interchange between any of the members in the panel, any discussion and any comment on the others remarks.

So with that we will proceed.

PANEL ON DENTISTRY CONSISTING OF PAUL W. KUNKEL, D.D.S., CHAIRMAN, COUNCIL ON LEGISLATION, AMERICAN DENTAL ASSOCIATION, ACCOMPANIED BY ERIC BISHOP, ASSISTANT EXECUTIVE DIRECTOR, ADA, AND ON BEHALF OF ACADEMY OF GENERAL DENTISTRY AND DELTA DENTAL PLANS ASSOCIATION; LOUIS J. TERKLA, D.D.S., PRESIDENT, AMERICAN ASSOCIATION OF DENTAL SCHOOLS; CHARLES A. CLARK, D.D.S., CHIEF, DIVISION OF DENTAL HEALTH, METROPOLITAN HEALTH PLANNING CORP., CLEVELAND, OHIO; TERRY W. SLAUGHTER, D.D.S., VICE PRESIDENT, AMERICAN SOCIETY OF ORAL SURGEONS; JAY FRIEDMAN, D.D.S., DENTAL DIRECTOR, U.S. ADMINISTRATORS, BEVERLY HILLS, CALIF.; RALPH R. LOBENE, D.D.S., DIRECTOR, FORSYTH STUDY OF NEW DUTIES FOR DENTAL HYGIENISTS, BOSTON, MASS.; CHARLES E. WILLIAMS, JR., D.D.S., PRESIDENT, NATIONAL DENTAL ASSOCIATION; AND BYARD DEPUTY, D.D.S., DIRECTOR, DIVISION OF DENTISTRY, UNIVERSITY OF VIRGINIA MEDICAL CENTER, CHARLOTTESVILLE, VA.

Mr. Cotter. Dr. Kunkel, would you like to lead off please?

STATEMENT OF PAUL W. KUNKEL, D.D.S.

Dr. Kunkel. Yes, Mr. Chairman.

I am Dr. Paul Kunkel, of Portland, Oreg. In addition to maintaining a private dental practice, I am chairman of the Council on Legislation of the American Dental Association. I am representing the American Dental Association, the Academy of General Dentistry, and the Delta Dental Plans Association. With me, immediately behind me, is Mr. Eric Bishop, assistant executive director of the American Dental Association.

As always we appreciate the opportunity to appear before this committee. The American Dental Association has had the privilege of appearing before you on other occasions on this subject. During the course of the hearings held in 1974 the Association submitted a detailed statement of its policies relating to dentistry's position in a national health program. Also included were specific recommendations and proposed amendments to the bills then pending, many of which have been reintroduced and are currently before the committee.

We would hope that the relevant portions of our previous testimony will be utilized as reference material during the present considerations. (Hearings, Ways and Means Committee on National Health Insurance, 93d Cong., vol. 3, pp. 1173–98.)

In addition, I would ask permission today to submit for the record a number of exhibits dealing with estimates of cost of dental benefits at various levels and scopes of coverage; the availability of dental manpower and other resources, and similar matters.

Mr. Cotter. Without objection so ordered.

[The exhibits follows:]

Exhibits on Dental Care Data Submitted by the American Dental Association

INDEX OF EXHIBITS

1. Cost summaries of dental care components of health insurance programs adjusted for utilization rates by economic class and age.
2. Estimated costs of comprehensive dental care programs.
3. Estimated costs of emergency dental care.
4. Estimated costs of emergency dental care, adjusted by income class.
5. Omitted.
6. Table of personal dental care expenditures by source of funds.
7. Table of number of individuals enrolled in private health insurance plans.
8. Table of private insurance dental benefit expenditures.
9. Table of the percentage of eligible population utilizing dental care benefits.
10. Comparison of aggregate (public and private) expenditures for health care services and dental care services.
11. Comparison of aggregate per capita expenditures for health care services and dental care services.
12. Comparison of dental care expenditures and health care expenditures for three age groups.
13. Chart of dental care expenditures as percentage of health care expenditures for three age groups.
14. Chart of aggregate expenditures for dental care for three age groups.
15. Chart of aggregate expenditures per capita expenditures for dental care for three age groups.

16. Chart of public expenditures for dental care as a percentage of total expenditures for dental care, for three age groups.
17. Comparison of consumer and public assistance expenditures for dental care.
18. Data on consumer expenditures for dental care.
19. Article in Journal of American Dental Association, Vol. 89, Dec. 1974, "Expenditures and Prices for Dental and Other Health Care, 1935–1973".
20. Index of dentists' fees, professional expenses, and salary expenses, 1967–1974. (Estimated index, 1974).
21. Comparative consumer price index of dental fees, physician fees, medical care, semiprivate room rates, etc.
22. Indexes of dentists' productivity related to auxiliaries employed.
23. Dental Manpower Growth.

Exhibit 1

COST SUMMARY FOR 1975—DENTAL CARE COMPONENT OF HEALTH INSURANCE PROGRAM, AGES 2 TO 17

[Population adjusted for utilization rates by economic class and age, fully funded program and selected copayment]

Age and economic class	In thousands				
	100 percent paid	90 to 10 percent copay	80 to 20 percent copay	75 to 25 percent copay	70 to 30 percent copay
2 to 4:					
Class I (under $5,000)	$5, 592	$4, 921	$4, 243	$3, 914	$3, 579
Class II ($5,000 to $9,999)	11, 793	10, 378	8, 963	8, 255	7, 548
Class III ($10,000 plus)	32, 253	28, 382	24, 512	22, 577	20, 642
All classes	49, 638	43, 681	37, 718	34, 746	31, 769
5 to 9:					
Class I	51, 834	45, 614	39, 394	36, 284	33, 174
Class II	109, 400	96, 272	83, 144	76, 580	70, 016
Class III	299, 129	263, 233	227, 338	209, 390	191, 442
All classes	460, 363	405, 119	349, 876	322, 254	294, 632
10 to 13					
Class I	52, 449	46, 155	39, 861	36, 714	33, 567
Class II	110, 645	97, 367	84, 090	77, 451	70, 813
Class III	302, 625	226, 310	229, 995	211, 837	193, 680
All classes	465, 719	409, 832	353, 946	326, 002	298, 060
Subtotal: 2 to 13:					
Class I	109, 876	96, 691	83, 506	76, 913	70, 321
Class II	231, 838	204, 018	176, 197	162, 287	148, 376
Class III	634, 007	557, 926	481, 845	443, 805	405, 764
All classes	975, 721	858, 635	741, 548	683, 005	624, 461
14 to 17:					
Class I	71, 913	63, 283	54, 654	50, 339	46, 024
Class II	151, 605	133, 412	115, 220	106, 123	97, 027
Class III	414, 726	364, 959	315, 192	290, 308	265, 424
All classes	638, 244	561, 654	485, 066	446, 770	408, 475
2 to 17:					
Class I	181, 789	159, 974	138, 160	127, 252	116, 345
Class II	383, 443	337, 430	291, 417	268, 410	245, 403
Class III	1, 048, 732	922, 884	797, 036	734, 113	671, 188
All classes	1, 613, 964	1, 420, 288	1, 226, 613	1, 129, 775	1, 032, 936

TABLE 1—COST OF DENTAL COMPONENT IN 1975, AGES 2 TO 17, FOR ECONOMIC CLASS I (UNDER $5,000), POPULATION ADJUSTED FOR UTILIZATION RATES BY ECONOMIC CLASS AND AGE, 100 PERCENT OF COST PAID

Age	Under $3,000		$3,000 to $4,999		Class I (under $5,000) population utilizing (thousands)	Age group subtotal population utilizing	Annual cost per patient	Program cost (population utilizing x costs per patient)
	Adjustment factor	Population utilizing (thousands)	Adjustment factor	Population utilizing (thousands)				
2	0.0439	15.76	0.0526	20.99	36.75			
3	.0439	15.28	.0526	20.36	35.64			
4	.0439	14.79	.0526	19.73	34.52			
Subtotal, 2 to 4						106,910	$52.31	$5,592,462
5	.2345	76.45	.2812	102.08	178.53			
6	.2345	74.10	.2812	98.98	173.08			
7	.2345	72.93	.2812	97.01	169.94			
8	.2345	75.27	.2812	100.39	175.66			
9	.2345	77.85	.2812	103.48	181.33			
Subtotal, 5 to 9						878,450	59.00	51,833,860
10	.2345	82.31	.2812	109.95	192.26			
11	.2345	86.30	.2812	115.01	201.31			
12	.2345	87.70	.2812	116.98	204.68			
13	.2345	89.34	.2812	118.95	208.29			
Subtotal, 10 to 13						806,540	65.03	52,449,296
Subtotal, 2 to 13						1,791,990		109,875,618
14	.2345	91.46	.2812	121.76	213.22		65.03	13,865,697
15	.2217	83.80	.2659	111.68	195.48		99.11	19,374,023
16	.2217	83.80	.2659	111.68	195.48		99.11	19,374,023
17	.2217	83.58	.2659	111.15	194.73		99.11	19,299,690
Subtotal, 15 to 17						798,910		71,913,433
Total, 2 to 17						2,590,900		181,789,051

Notes: Estimated 1975 and 1980 population by age groups for economic classes I, II, and III are from appendix tables 1B and 1C of "Dentistry in National Health Programs-Reports of the Special Committees," 1971. Population projections in the report were based on U.S. Bureau of the Census, current population reports, series P-25, No. 448, 1970. Income classes were defined in 1968 dollars. Adjustment factors were derived from percentage of population with dental visits within a year, table A, "Dental Visits—Volume and Interval Since Last Visit, U S., 1969," published by U.S. Department of HEW, Vital and Health Statistics Series 10 No. 76, 1972, The factor is the percentage visiting a dentist in the 2 to 4 and 5 to 13 year age groups, adjusted by the ratio of visits in each income class to visits in the highest income class. Annual per capita cost and utilization under various forms of copayment are based on projected costs for 1974-76 prepared by Delta Dental Plans Association from experience data. Costs are in 1973 dollars. Above estimates include the cost of emergency dental care.

TABLE 2.—COST OF DENTAL COMPONENT IN 1975, AGES 2 to 17, FOR ECONOMIC CLASS II ($5,000 TO $9,999), POPULATION ADJUSTED FOR UTILIZATION RATES BY ECONOMIC CLASS AND AGE 100 PERCENT PAID AND SELECTED COPAYMENTS

Age	$5,000 to $6,999		$7,000 to $9,999		Class II ($5,000 to $9,999) population utilizing (thousands)	Age group subtotal population utilizing
	Adjustment factor	Population utilizing (thousands)	Adjustment factor	Population utilizing (thousands)		
2	0.0617	27.02	0.0744	50.44	77.46	
3	.0617	26.22	.0744	48.96	75.18	
4	.0617	25.42	.0744	47.39	72.81	
Subtotal 2 to 4						225,450
5	.3297	131.55	.3976	245.32	376.87	
6	.3297	127.59	.3976	237.76	365.35	
7	.3297	125.29	.3976	233.39	358.68	
8	.3297	129.57	.3976	241.34	370.91	
9	.3297	133.53	.3976	248.90	382.43	
Subtotal 5 to 9						1,854,240
10	.3297	141.77	.3976	264.01	405.78	
11	.3297	148.04	.3976	276.33	424.37	
12	.3297	150.67	.3976	280.71	431.38	
13	.3297	153.64	.3976	286.27	439.91	
Subtotal 10 to 13						1,701,440
Subtotal 2 to 13						
14	.3297	156.94	.3976	292.63	449.57	
15	.3117	144.00	.3759	268.02	412.02	
16	.3117	144.00	.3759	268.02	412.02	
17	.3117	143.38	.3759	267.26	410.64	
Subtotal 14 to 17						1,684,250
Total 2 to 17						5,465,380

Note: For technical explanation see Notes below table 1.

Age	Annual cost per patient					Program cost (population utilizing X cost per patient)				
	100 percent paid	90 to 10 copay (factor =.88)	80 to 20 copay (F =.76)	75 to 25 copay (F =.70)	70 to 30 copay (F =.64)	100 percent paid	90 to 10 copay	80 to 20 copay	75 to 25 copay	70 to 30 copay
Subtotal 2 to 4	$52.31	$46.03	$39.76	$36.62	$33.48	$11,793,290	$10,378,095	$8,962,900	$8,255,303	$7,547,706
Subtotal 5 to 9	59.00	51.92	44.84	41.30	37.76	109,400,160	96,272,141	83,144,122	76,580,112	70,016,102
Subtotal 10 to 13	65.03	57.23	49.42	45.52	41.62	110,644,643	97,367,286	84,089,929	77,451,250	70,812,572
Subtotal 2 to 13						231,838,093	204,017,522	176,196,951	162,286,665	148,376,380
14	65.03	57.23	49.42	45.52	41.62	29,235,537	25,727,273	22,219,008	20,464,876	18,710,744
15	99.11	87.22	75.32	69.38	63.43	122,369,135	107,684,839	93,000,543	85,658,395	78,316,246
16	99.11	87.22	75.32	69.38	63.43					
17	99.11	87.22	75.32	69.38	63.43					
Subtotal 14 to 17						151,604,672	133,412,112	115,219,551	106,123,271	97,026,990
Total 2 to 17						383,442,765	337,429,634	291,416,502	268,409,936	245,403,370

TABLE 3.—COST OF DENTAL COMPONENT IN 1975, AGES 2 To 17, FOR ECONOMIC CLASS III ($10,000 PLUS), POPULATION ADJUSTED FOR UTILIZATION RATES BY ECONOMIC CLASS AND AGE, 100 PERCENT PAID AND SELECTED COPAYMENT

Age	$10,000 to $14,999		$15,000 and up		Class III ($10,000 and up) population utilizing	Age group subtotal population utilizing
	Adjustment factor	Population utilizing	Adjustment factor	Population utilizing		
		(Thousands)		*(Thousands)*	*(Thousands)*	
2	0.0909	97.81	0.11	114.07	211.88	
3	.0909	94.90	.11	110.66	205.56	
4	.0909	91.99	.11	107.14	199.13	
Subtotal 2 to 4						616,570
5	.4857	475.99	.588	554.48	1,030.47	
6	.4857	461.42	.588	537.43	998.85	
7	.4857	452.67	.588	528.02	980.69	
8	.4857	468.21	.588	546.25	1,014.46	
9	.4857	482.79	.588	562.72	1,045.51	
Subtotal 5 to 9						5,069,980
10	.4857	512.41	.588	596.82	1,109.23	
11	.4857	536.21	.588	625.04	1,161.25	
12	.4857	544.96	.588	635.63	1,180.59	
13	.4857	555.16	.588	647.39	1,202.55	
Subtotal 10 to 13						4,653,620
Subtotal 2 to 13						
14	.4857	567.78	.588	661.50	1,229.28	
15	.4593	520.39	.556	606.60	1,126.99	
16	.4593	520.39	.556	606.60	1,126.99	
17	.4593	519.01	.556	604.93	1,123.94	
Subtotal 14 to 17						4,607,200
Total 2 to 17						14,947,370

Notes: For technical explanation see notes below table 1.

Age	Annual cost per patient					Program cost (population utilizing X cost per patient)				
	100 percent paid (factor=.88)	90 to 10 copay (factor=.88)	80 to 20 copay (F=.76)	75 to 25 copay (F=.70)	70 to 30 copay (F=.64)	100 percent paid	90 to 10 copay	80 to 20 copay	75 to 25 copay	70 to 30 copay
Subtotal 2 to 4	$52.31	$46.03	$39.76	$36.62	$33.48	$32,252,777	$28,382,444	$24,512,111	$22,576,944	$20,641,777
Subtotal 5 to 9	59.00	51.92	44.84	41.30	37.76	299,128,820	263,233,362	227,337,903	209,390,174	191,442,445
Subtotal 10 to 13	65.03	57.23	49.42	45.52	41.62	302,624,909	266,309,920	229,994,931	211,837,436	193,679,942
Subtotal 2 to 13						634,006,506	557,925,726	481,844,945	443,804,554	405,764,164
14	65.03	57.23	49.42	45.52	41.62	79,940,078	70,347,269	60,754,459	55,958,055	51,161,650
15	99.11	87.22	75.32	69.38	63.43	334,785,651	294,611,373	254,437,095	234,349,956	214,262,817
16	99.11	87.22	75.32	69.38	63.43					
17	99.11	87.22	75.32	69.38	63.43					
Subtotal 14 to 17						414,725,729	364,958,642	315,191,554	290,308,011	265,424,467
Total 2 to 17						1,048,732,235	922,884,368	797,036,499	734,112,565	671,188,631

EXHIBIT 2

ESTIMATED COST OF COMPREHENSIVE DENTAL CARE PROGRAM (100 PERCENT FUNDED), BY AGE AND INCOME CLASS

Age and income class	Covered population (millions) [1]	Utilizing population (millions) [2]	Cost per patient [3]	Cost of program (millions)
2 to 17:				
Class I (under $5,000)	10.9	4.0	$65	$260
Class II ($5,000 to $9,999)	16.4	6.8	65	442
Class III ($10,000 plus)	30.4	14.9	65	968
All classes	57.7	25.7		1,670
18 to 64:				
Class I	26.4	10.6	118	1,251
Class II	34.0	14.3	118	1,687
Class III	62.4	28.1	118	3,316
All classes	122.8	53.0		6,254
65 plus:				
Class I	10.4	2.3	137	315
Class II	6.7	1.5	137	206
Class III	6.9	1.5	137	206
All classes	24.0	5.3		727
Total (2 and above), all classes	204.5	84.0		8,651

[1] Population July 1, 1974.

[2] Utilization for age groups adjusted for income levels, based on data in table A, "Dental Visits—Volume and Interval Since Last Visit, United States 1969," published by U.S. Department of HEW, Vital and Health Statistics Series 10 No. 76, 1972.

[3] Cost per patient projected for national health insurance program, based on experience data of Delta Dental Plans Association.

Notes: Utilization rate and cost per patient from estimate by California Dental Service, based on experience of Denti-Cal program, 1974. Original estimate adjusted for variations, in utilization and cost per ptaient by income class and age, based on data in table A, "Dental Visits—Volume and Interval Since Last Visit, United States, 1969," published by U.S. Department of HEW, Vital and Health Statistics Series 10 No. 76, 1972.

EXHIBIT 3

ESTIMATED COST OF EMERGENCY DENTAL CARE, AGES 5 AND ABOVE, WITH 2 TO 6 PERCENT UTILIZATION RATE, COST PER PATIENT $25 TO $50

Age group	Population July 1, 1974 (million)	Average utilization rate (percent)	Utilizing population (million)	Cost per patient	Total cost (million)
5 to 13	34.1	5.47	1,865	$25	$46.7
14 to 17	16.9	5.47	.924	35	32.4
18 to 64	122.8	5.49	6.744	50	337.2
65 and above	24.0	2.46	.651	30	19.5
Total	197.8		10.184		435.8

Notes: Definition of emergency dental care services, adopted by the House of Delegates, 1975, as follows:

These services should be available to those eligible for the program from the 1st day of the program.

Control of oral and maxillofacial bleeding in any condition when loss of blood will jeopardize the patient's well-being. Treatment may consist of any professionally accepted procedure deemed necessary.

Relief of respiratory difficulty from any oral and maxillofacial condition which can involve the airway (respiratory system) in a life-threatening manner. Treatment may consist of any professionally accepted procedure deemed necessary.

Relief of severe pain accompanying any oral or maxillofacial condition affecting the nervous system, limited to immediate palliative treatment only but including extractions where professionally indicated.

Immediate and palliative procedures for (1) fractures, subluxations and avulsions of teeth, (2) fractures of jaws and other facial bones (reduction and fixation only), (3) temporomandibular joint subluxations and (4) soft tissue injuries.

Initial treatment for acute infections.

Emergency dental care services include (1) all necessary laboratory and preoperative work, including examination and radgraphs and (2) appropriate anesthesia (local, general, sedative) for optimal management of the emergency.

Exhibit 4

ESTIMATED COST OF EMERGENCY DENTAL CARE, AGES 5 AND ABOVE, WITH 2 TO 6 PERCENT UTILIZATION RATE (ADJUSTED BY INCOME CLASS), COST PER PATIENT $25 TO $50

Age group and income class	Population July 1, 1974 (millions)	Utilization rate (percent)	Utilizing population (millions)	Cost per patient	Total cost (millions)
5 to 13:					
Class I (under $5,000)	6.5	6	0.390	$25	$9.8
Class II ($5,000 to $9,999)	9.5	6	.570	25	14.3
Class III ($10,000 and over)	18.1	5	.905	25	22.6
All income classes	34.1		1.865		46.7
14 to 17:					
Class I	3.2	6	.192	35	6.7
Class II	4.7	6	.282	35	9.9
Class III	9.0	5	.450	35	15.8
All income classes	16.9		.924		32.4
18 to 64:					
Class I	26.4	6	1.584	50	79.2
Class II	34.0	6	2.040	50	102.0
Class III	62.4	5	3.120	50	156.0
All income classes	122.8		6.744		337.2
65 and over:					
Class I	10.4	3	.312	30	9.4
Class II	6.7	3	.201	30	6.0
Class III	6.9	2	.138	30	4.1
All income classes	24.0		.651		19.5
5 and above, all income classes	197.8		10.184		435.8

Exhibit 5 is omitted.

Exhibit 6

TABLE 4.—DENTISTS' SERVICES: PERSONAL HEALTH CARE EXPENDITURES BY SOURCE OF FUNDS

	Total for dentists' services			Private expenditures[2]			Government[3]		
	Percent of personal health care	Millions	Growth rate[1] (percent)	Percent of total	Millions	Growth rate[1] (percent)	Percent of total	Millions	Growth rate[1] (percent)
Growth rate:[1]									
1971–74			8.1			7.9			11.4
1965–71			10.3			9.6			[4] 6.6
1974	6.9	$6,200	7.5	94.5	$5,858	7.4	5.5	$342	10.0
1973	7.0	5,767	8.0	94.6	5,456	7.7	5.4	311	12.7
1972	7.2	5,342	8.8	94.8	5,066	8.7	5.2	276	11.7
1971	7.3	4,908	9.7	95.0	4,661	9.3	5.0	247	18.8
1970	7.4	4,473	14.1	95.3	4,265	15.7	4.7	208	(12.1)
1969	7.4	3,920	11.4	94.0	3,686	11.2	6.0	234	14.7
1968	7.6	3,518	11.4	94.2	3,314	7.7	5.8	204	151.8
1967	7.6	3,158	10.2	97.4	3,077	9.0	2.6	81	84.1
1966	7.9	2,866	5.1	98.5	2,822	4.7	1.5	44	33.3
1965	8.1	2,728	7.0	98.8	2,695	6.8	1.2	33	[5] NM
1960	8.6	1,944		99.8	1,941		.2	3	

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[1] Compound annual rate of increase for period shown and from previous year.

[2] Private expenditures for dentists' services in 1974 include $532,000,000 private insurance benefits.

[3] Government expenditures for dentists' services in 1974 include $267,000,000 paid for under medicaid and other public assistance programs. This amount was 78 percent of total Government expenditures for dentists' services.

[4] Growth rate 1967–71.

[5] Not meaningful.

Source: U.S. Department of Health, Education and Welfare.

EXHIBIT 7

TABLE 5.—NUMBER OF INDIVIDUALS ENROLLED IN PRIVATE HEALTH INSURANCE PLANS

	Dental care		Dental care by type of insurance (thousands)				Hospital care[1]		Physicians' Surgical services[2]	
	Thousands	Percent of population	Insurance companies	Dental service corporations	Blue-Cross Blue-Shield	Independent plans	Thousands	Percent of population	Thousands	Percent of population
1973	21, 626	10. 4	11, 328	5, 500	1, 740	3, 058	158, 475	75. 8	156, 913	75. 1
1972	17, 904	8. 6	9, 087	4, 800	1, 100	2, 907	159, 526	77. 0	153, 326	74. 0
1971	15, 348	7. 5	7, 913	3, 500	1, 100	2, 835	157, 186	76. 5	151, 694	73. 8
1970	12, 210	6. 0	6, 685	3, 000	275	2, 250	154, 263	75. 9	150, 001	73. 9
1969	8, 510	4. 2	4, 811	1, 713	141	1, 845	(2)	(2)	(2)	(2)
1968	5, 821	2. 9	3, 124	1, 476	35	1, 195	150, 888	75. 9	148, 082	74. 5
1967	[3] 4, 679	2. 4	2, 439	1, 045	20	1, 175	145, 454	73. 9	142, 082	72. 2
Compound annual growth rate, 1967-73 (percent)	29. 1		29. 2	31. 9	(4)	17. 3	1. 4		1. 7	

[1] Another source, the Health Insurance Association of America, estimates a higher level of coverage. For example, 1973 estimates for hospital care are 182,100,000, equal to 87.1 percent of the total population (170,200,000 and 54.8 percent of the population under age 65). The 1973 estimates for physicians' surgical services are 169,400,000 and 81.1 percent (159,500,000 and 85.1 percent of the population under age 65).

[2] Not available.

[3] Total as reported, however, individual categories add to 4,699.

[4] Not meaningful. Estimates of the net number of different persons under private health insurance plans.

Note: 1973 coverage for persons under age 65 is as follows (thousands): Hospital care—146,089 (78 percent of population), physicians' services—145,352 (77.6 percent), and dental care—21,392 (11.4 percent). Data for persons under age 65 is frequently used to measure insurance coverage because more than 90 percent of the population over age 65 are covered by medicare—part A (hospital insurance) and part B (physicians' fees and other medical insurance).

Source: U.S. Department of Health, Education, and Welfare.

EXHIBIT 8

TABLE 6.—PRIVATE INSURANCE BENEFIT EXPENDITURES

[In millions of dollars]

	Total	Insurance companies	Dental service corporations	Blue-Cross Blue-Shield	Independent plans
Calendar year—					
1973	519.8	249.0	200.2	23.0	47.6
1972	389.4	207.0	130.0	13.3	39.1
1971	304.3	194.0	60.0	8.9	41.4
1970	240.1	147.0	54.0	3.8	35.3
1969	154.8	83.0	46.2	2.4	23.2
1968	104.6	59.0	28.5	6.1	11.0
1967	(1)	[2] 42.0	(1)	(1)	(1)
Compound annual growth rate: 1967–73 (percent)	[3] 37.8	34.5	[3] 34.1	[3] 30.4	[3] 30.4

[1] Not available.
[2] Estimate by Health Insurance Association of America.
[3] Growth rate 1968–73.

Source: U.S. Department of Health, Education, and Welfare, except as noted.

EXHIBIT 9

TABLE 7.—DENTAL CARE—SAMPLE UTILIZATION DATA

[Percentage of eligible population using benefits]

	Year of program				
	1st	2d	3d	4th	5th
American Dental Association program:					
Adults	59.3	50.4		59.5	58.0
Children	58.5	57.0		68.3	55.6
ILWU program for children:					
Under dental service plan	68.0	55.0	55.0		
Under insurance plan	54.0	44.0	38.0		
Under group practice (children who actually received care)	68.0	59.0	60.0		
California Dental Service estimated averages	52.0	57.0	60.0		
Research study on annual utilization:					
Under dental service plan	42.0				
Under insurance plan	32.0				
Under group practice	42.0				
Research study on prepaid dental care:					
Under dental service plan	48.9	53.8			
Under group practice	53.0	43.0			
Los Angeles Hotel-Restaurant dental clinic	41.5	41.0	45.7	47.8	48.0
Labor Health Institute, St. Louis (closed panel) estimated average	60.0				

Source: Table from report of Quality Review and Payment Mechanisms 1971 Committee of the American Dental Association Task Force on National Dental Health Programs (specific references omitted).

Exhibit 10

AGGREGATE (PRIVATE AND PUBLIC) EXPENDITURES FOR HEALTH CARE SERVICES AND DENTAL CARE SERVICES 1950–74

[Dollar amounts in billions]

Year	Health care expenditures	Expenditures for dentists' services	Dental care as percent of health care expenditures
1950	$12.0	$0.9	7.8
1955	17.3	1.5	8.4
1960	25.9	1.9	7.3
1965	38.9	2.7	7.0
1970	69.2	4.5	6.5
1971	77.1	4.9	6.4
1972	86.3	5.3	6.1
1973	94.3	5.7	6.1
1974	104.2	6.2	5.9

Source: Table 4, National Health Expenditures, 1929–74, by Nancy L. Worthington, Social Security Bulletin, February 1975.

Exhibit 11

AGGREGATE (PRIVATE AND PUBLIC) PER CAPITA EXPENDITURES FOR HEALTH CARE SERVICES AND DENTAL CARE SERVICES, 1950–74

Year	Per capita health care expenditures	Per capita expenditures for dentists' services	Per capita dental care expenditures as percent of per capita health care expenditures
1950	$78.35	6.12	7.8
1955	103.76	8.72	8.4
1960	141.63	10.65	7.5
1965	197.75	13.87	7.0
1970	333.57	21.56	6.5
1971	368.25	23.42	6.4
1972	408.31	25.25	6.2
1973	441.94	27.05	6.1
1974	485.36	28.87	5.9

Source: Table 4, National Health Expenditures, 1929–74, by Nancy L. Worthington, Social Security Bulletin, February, 1975.

Exhibit 12

DENTAL CARE EXPENDITURES AND HEALTH CARE EXPENDITURES FOR 3 AGE GROUPS, 1967–74

[In millions of dollars]

Year	Dental expenses			Health care expenses		
	Total	Private	Public	Total	Private	Public
All ages:						
1967	3,158	3,077	81	41,323	28,863	12,461
1968	3,498	3,295	203	46,323	30,118	16,205
1969	3,821	3,589	232	52,020	33,309	18,711
1970	4,245	4,041	204	58,752	38,225	20,526
1971	4,660	4,400	260	65,132	41,841	23,291
1972	5,342	5,066	277	74,688	47,738	26,949
1973	5,767	5,456	311	81,859	51,886	29,972
1974	6,200	5,858	342	90,281	56,028	34,253
Under 19:						
1967	780	748	32	6,980	5,370	1,610
1968	888	801	87	7,662	5,738	1,922
1969	983	872	111	8,493	6,232	2,261
1970	1,069	982	87	9,499	7,036	2,461
1971	1,171	1,069	102	10,465	7,654	2,813
1972	1,189	1,089	100	11,531	8,246	3,283
1973	1,283	1,173	110	12,486	8,912	3,575
1974	1,389	1,260	129	13,416	9,805	3,611
19 to 64:						
1967	2,118	2,083	35	24,352	19,147	5,205
1968	2,327	2,231	96	26,560	20,459	6,102
1969	2,521	2,430	91	29,478	22,741	6,737
1970	2,826	2,736	90	33,242	25,802	7,440
1971	3,103	2,979	124	36,804	28,407	8,396
1972	3,779	3,632	147	41,510	30,586	10,924
1973	4,082	3,912	170	45,495	33,343	12,153
1974	4,383	4,200	183	50,189	35,626	14,561
65 and over:						
1967	259	246	13	9,990	4,347	5,644
1968	284	264	20	12,102	3,923	8,179
1969	318	287	31	14,049	4,333	9,714
1970	350	323	27	16,012	5,387	10,625
1971	386	352	34	17,863	5,782	12,082
1972	375	345	30	21,649	8,905	12,742
1973	402	371	31	23,877	9,633	14,244
1974	429	398	31	26,678	10,597	16,082

Source: Social Security Bulletin, May 1972 and 1975.

EXHIBIT 13

DENTAL CARE EXPENDITURES AS PERCENTAGE OF HEALTH CARE EXPENDITURES FOR 3 AGE GROUPS, 1967–74

Year	Total dental expenditures as percent of total health expenditures	Private dental expenditures as percent of private health expenditures	Public dental expenditures as percent of public health expenditures
All ages:			
1967	7.6	10.7	0.6
1968	7.5	10.9	1.2
1969	7.3	10.8	1.2
1970	7.2	10.6	1.0
1971	7.1	10.5	1.1
1972	7.1	10.6	1.0
1973	7.0	10.5	1.6
1974	6.9	10.4	1.0
Under 19:			
1967	11.2	13.9	2.0
1968	11.6	13.9	4.5
1969	11.6	13.9	4.9
1970	11.2	11.1	3.5
1971	11.2	14.0	3.6
1972	10.3	13.2	3.0
1973	10.3	13.2	3.1
1974	10.3	12.8	3.6
19 to 64:			
1967	8.7	10.9	.7
1968	8.8	10.9	1.6
1969	8.5	10.7	1.3
1970	8.5	10.6	1.2
1971	8.4	10.5	1.5
1972	9.1	11.9	1.3
1973	9.0	11.7	1.4
1974	8.7	11.8	1.2
65 and over:			
1967	2.6	5.6	.2
1968	2.3	6.7	.2
1969	2.3	6.6	.3
1970	2.2	6.0	.2
1971	2.2	6.1	.3
1972	1.7	3.9	.2
1973	1.7	3.8	.2
1974	1.6	3.7	.2

Source: Based on statistics in "Social Security Bulletin " May 1972 and 1975.

EXHIBIT 14

AGGREGATE (PRIVATE AND PUBLIC) EXPENDITURES FOR DENTAL CARE FOR 3 AGE GROUPS, 1967–74

[Dollar amounts in millions]

Year	All ages					Under 19			19 to 64			65 and over		
	Total	Private	Private as percent of total	Public	Public as percent of total	Total	Private	Public	Total	Private	Public	Total	Private	Public
1967	$3,158	$3,077	97.4	$81	2.6	$780	$748	$32	$2,118	$2,083	$35	$259	$246	$13
1968	3,498	3,295	94.2	203	5.8	888	801	87	2,327	2,231	96	284	264	20
1969	3,821	3,589	93.9	232	6.1	983	872	111	2,521	2,430	91	318	287	31
1970	4,245	4,041	95.2	204	4.8	1,069	928	87	2,826	2,736	90	350	323	27
1971	4,660	4,400	94.4	260	5.6	1,171	1,069	102	3,103	2,979	124	386	352	34
1972	5,342	5,006	93.7	277	6.3	1,189	1,089	100	3,779	3,682	147	375	345	30
1973	5,767	5,456	94.6	311	5.4	1,283	1,173	110	4,082	3,912	170	402	371	31
1974	6,200	5,858	94.5	342	5.5	1,389	1,260	129	4,383	4,200	183	429	398	31

Source: "Social Security Bulletin," May 1972 and 1975.

Exhibit 15

AGGREGATE (PRIVATE AND PUBLIC) PER CAPITA EXPENDITURES FOR DENTAL CARE FOR 3 AGE GROUPS, 1967–74

Year	All ages			Under 19			19 to 64			65 and over		
	Total	Private	Public	Total	Private	Public	Total	Private	Public	Total	Private	Public
1967	$15.71	$15.30	$0.40	$10.80	$10.37	$0.43	$19.48	$19.16	$0.33	$13.76	$13.07	$0.69
1968	17.21	16.21	1.00	11.83	10.67	1.16	21.36	20.48	.88	14.76	13.67	1.09
1969	18.58	17.44	1.14	13.07	11.59	1.48	22.77	21.94	.82	16.08	14.51	1.57
1970	20.00	18.84	1.16	13.98	12.55	1.44	24.57	23.69	.89	17.28	15.68	1.61
1971	22.24	21.00	12.4	15.66	14.29	1.36	27.23	26.14	1.09	18.61	16.97	1.63
1972	25.25	23.94	1.31	15.87	14.54	1.34	32.65	31.38	1.27	17.90	16.47	1.44
1973	27.05	25.59	1.46	17.34	15.85	1.49	34.62	33.18	1.44	18.85	17.40	1.45
1974	28.87	27.28	1.59	18.97	17.20	1.76	36.64	35.11	15.3	19.58	18.17	1.42

Source: "Social Security Bulletin," May 1972 and 1973, June 1975.

Exhibit 16

PUBLIC EXPENDITURES FOR DENTAL CARE AS A PERCENTAGE OF TOTAL EXPENDITURES FOR DENTAL CARE, FOR 3 AGE GROUPS, 1967–74

Year	All ages (percent)	Public as percent of total—		
		Under 19	19 to 64	65 and over
1967	2.6	4.1	1.6	5.0
1968	5.8	9.8	4.1	7.0
1969	6.1	11.3	3.6	9.7
1970	4.8	8.1	3.2	7.7
1971	5.6	8.8	4.0	8.8
1972	6.3	8.4	3.9	8.0
1973	5.4	8.6	4.2	7.7
1974	5.5	9.3	4.2	7.2

Source: Based on data from "Social Security Bulletin," May 1972 and 1975.

Exhibit 17

CONSUMER EXPENDITURES FOR DENTAL CARE

Year	Total consumer expenditure for dentistry	Percentage health dollar	Per capita expenditure
1973	$4,901,000,000	7.8	$23.55
1971	4,660,000,000	9.1	22.81
1970	4,289,000,000	9.2	21.26
1969	3,921,000,000	9.3	19.70
1968	3,461,000,000	9.2	17.57
1965	2,836,000,000	10.1	14.78
1960	2,007,000,000	10.5	11.27
1950	962,000,000	10.9	6.40
1940	419,000,000	10.9	3.18

PUBLIC ASSISTANCE EXPENDITURES FOR DENTISTRY

Fiscal year	Expenditure	Percentage of total public assistance medical care expenditures
1973	$212,000,000	2.3
1972	185,000,000	2.4
1971	179,900,000	2.9
1970	170,900,000	3.4
1969	210,600,000	4.6
1968	193,400,000	5.4
1965	30,800,000	2.1

GENERAL AND HEALTH CARE INCREASES

[Base: 1967 equals 100]

	1960	1973	Percent change
Consumer Price Index, all items	88.7	133.1	50.1
Consumer Price Index, commodities	91.5	129.9	42.0
Consumer Price Index, services	83.5	139.1	66.6
Compensation per man-hour	70.2	146.5	108.7
Dentists' fees	82.1	136.4	66.1
Physicians' fees	77.0	138.2	79.5
Hospital daily services	56.3	176.5	213.5

Note: Consumer expenditures are direct payments by private individuals and benefit expenditures and administrative costs of private health insurance. Consumer expenditures do not include private philanthropic and public expenditures.

EXHIBIT 18

CONSUMER EXPENDITURES FOR DENTAL CARE, SELECTED YEARS 1950–73

Year	Consumer expenditures for dentists' services (millions) (1)	Percentage of health dollar spent for dentists' services (2)	(A) Per capita expenditures for dental care (3)	(B) Dental care price index (1967 equals 100) (4)	Amount of dental care in 1967 dollars per capita (A) divided by (B) per 100 (5)
1950	962	10.9	$6.38	63.9	9.98
1954	1,428	11.8	8.94	72.3	12.36
1958	1,876	11.4	10.89	78.6	13.85
1960	2,007	10.5	11.27	82.1	13.73
1962	2,265	10.3	12.33	84.7	14.56
1964	2,623	10.2	13.87	89.4	15.51
1966	2,970	9.5	15.36	95.2	16.13
1968	3,461	9.2	17.56	105.5	16.64
1969	3,921	9.2	19.69	112.9	17.44
1970	4,293	9.0	21.28	119.4	17.82
1971	4,312	8.3	21.11	127.0	16.62
1972	4,069	8.0	22.32	132.3	16.87
1973	4,901	7.8	23.55	136.4	17.26

Note: Percentage increase in per capita expenditure for dental care, 1950–73, 269 percent; percentage increase in amount of dental care per capita, 1950–73, 73 percent.

Sources: Column (1) Survey of Current Business (various issues, tables on personal consumption expenditures) U.S. Department of Commerce; column (4) Bureau of Labor Statistics, U.S. Department of Labor; Other columns calculated from preceding.

EXHIBIT 19

[From Reports of Councils and Bureaus, JADA, vol. 89, December 1974]

EXPENDITURES AND PRICES FOR DENTAL AND OTHER HEALTH CARE, 1935 TO 1973

BUREAU OF ECONOMIC RESEARCH AND STATISTICS

Since 1959, the Bureau of Economic Research and Statistics has prepared reports on consumer expenditures for dental care, amount of dental care per capita, and the Consumer Price Index. In this report and in earlier studies, the figures on consumer expenditures for dental care are from the US Department of Commerce. However, it should be noted that differences exist between these estimates and other sources of information. For example, the Social Security Administration estimated consumer expenditures for dental care in fiscal 1973 at $5.1 billion, and the Department of Commerce estimated them for calendar 1973 at $4.9 billion. In 1970, the National Center for Health Statistics estimated personal out-of-pocket dental expenditures at $5.8 billion in contrast to the $4.2 billion estimate of the Department of Commerce for consumer expenditures. According to the "Survey of Dental Practice," the Bureau of Economic Research and Statistics estimated the national dental bill at $4.8 billion in 1970 and $5.9 billion in 1972. The resulting per capita expense in 1970 was $21 (US Department of Commerce), $24 (Bureau of Economic Research and Statistics), and $29 (National Center for Health Statistics).

Nearly twice as much was spent for health care in the United States in 1973 than in 1966; the figures were $31,142,000,000 in 1966 and $62,726,000,000 in 1973, according to the Department of Commerce. Expenditures for dental care during this period increased from $3.0 billion to $4.9 billion. More than five times as much was spent for dental care in 1973 than in 1950 (Table 1). Since 1950 physicians and hospitals have received the largest portion of expenditures for health care; the 1973 figures are 26.5 percent and 36.6 percent respectively. Dentistry's portion of the health dollar decreased from 10.9 percent in 1950 to 7.8 percent in 1973. Similar declines occurred for all other items of health care during this period with the exception of hospitals and health insurance. Hospitals received 22.5 percent of the health dollar in 1950 and 36.6 percent in 1973—health insurance 6.9 percent in 1950 and 7.6 percent in 1973 (Table 2).

Consumer expenditures for items of health care as a percentage of total consumer expenditures are presented in Table 3. Items of health care accounted for 7.79 percent of total expenditures in 1973, a decrease from 7.85 percent in 1972. During this period, all items of health care received a lower percentage of total consumer expenditures with the exception of hospitals, which increased from 2.82 percent to 2.85 percent.

Tables 4 and 5 show the consumer price indexes for items of "medical care" and percent of increase for specified periods. Price indexes for dentists' fees increased at the same rate as the index for "all medical care" during 1970–1973. Between 1972–1973, the increase was 3.1 percent for dentists' fees, 3.9 percent for "all medical care," and 6.2 percent for all items. Hospital daily service charges showed the greatest increase during 1970–1973 compared with other items of health care. The figures were 22.7 percent for hospitals and 14.2 percent for both dentists' fees and "all medical care."

Table 6 shows amounts spent by consumers for various items in 1973 and their percent of total consumer expenditures. Dentistry's portion of total expenditures was 0.61 percent compared with 2.67 percent for alcoholic beverages, 6.4 percent for recreation, and 12.74 percent for user-operated transportation.

Amount of dental care per capita and per capita expense for dental care for various years are presented in Table 7. The amount of dental care per capita was calculated by dividing per capita expense for dental care by the dental care component of the Consumer Price Index. This procedure yields a measure of amount of dental care in terms of constant dollars. Per capita expense for dental care steadily increased from $2.38 in 1935 to $23.55 in 1973. In constant dollars (dental fees of 1967), the corresponding figures for these years are $5.83 and $17.27. As mentioned earlier, the estimates of consumer expenditures for dental care used in this study are from the US Department of Commerce. Compared with estimates made by other agencies, these figures appear unduly low—especially in recent years. The Department of Commerce has revised its figures in the past and may well do so in the future.

TABLE 1.—CONSUMER EXPENDITURES FOR HEALTH CARE, 1935 TO 1973

[In millions of dollars]

Item	1973	1972	1971	1970	1969	1968	1966	1964	1962	1960	1958	1954	1950	1940	1935
Dentists	4,901	4,609	4,312	4,293	3,921	3,461	2,970	2,623	2,265	2,007	1,876	1,428	962	419	302
Physicians	16,620	15,259	14,191	12,943	11,468	10,047	8,382	7,044	5,992	5,292	4,574	3,351	2,568	913	731
Other professional services	2,889	2,585	2,209	2,059	1,857	1,822	1,565	1,245	1,066	968	832	609	472	173	151
Drug preparations and sundries	8,592	8,004	7,285	6,945	6,429	5,873	5,133	4,331	4,012	3,607	3,195	2,163	1,719	635	474
Ophthalmic products and orthopedic appliances	2,034	1,842	1,697	1,745	1,729	1,700	1,583	1,056	895	769	663	595	486	186	131
Privately controlled hospitals and sanitariums	22,940	20,541	18,779	16,851	14,640	12,323	9,294	7,729	6,100	5,096	4,202	2,878	1,979	527	406
Health insurance[1]	4,750	4,390	3,291	2,565	2,770	2,541	2,215	1,775	1,672	1,377	1,130	1,022	602	165	93
Total	62,726	57,230	51,764	47,410	42,814	37,767	31,142	25,803	22,002	19,116	16,472	12,046	8,788	3,018	2,288

[1] Premiums minus claims paid.

Source: Survey of Current Business, U.S. Department of Commerce (various issues).

TABLE 2.—PERCENTAGE DISTRIBUTION OF THE HEALTH DOLLAR, 1935 TO 1973.

Item	1973	1972	1971	1970	1969	1968	1966	1964	1962	1960	1958	1954	1950	1940	1935
Dentists	7.8	8.0	8.3	9.0	9.2	9.2	9.5	10.2	10.3	10.5	11.4	11.8	10.9	13.9	13.2
Physicians	26.5	26.7	27.4	27.3	26.8	26.6	26.9	27.8	27.2	27.7	27.8	27.8	29.2	30.2	32.0
Other professional services	4.6	4.5	4.3	4.3	4.3	4.8	5.0	4.8	4.9	5.1	5.0	5.1	5.4	5.7	6.6
Drug preparations and sundries	13.7	14.0	14.1	14.7	15.0	15.6	16.5	16.8	18.2	18.9	19.4	18.0	19.6	21.0	20.7
Ophthalmic products and orthopedic appliances	3.2	3.2	3.3	3.7	4.0	4.5	5.1	4.1	4.1	4.0	4.0	4.9	5.5	6.2	5.7
Privately controlled hospitals and sanitariums	36.6	35.9	36.3	35.6	34.2	32.6	29.9	29.9	27.7	26.6	25.5	23.9	22.5	17.5	17.7
Health insurance	7.6	7.7	6.3	5.4	6.5	6.7	7.1	6.9	7.6	7.2	6.9	8.5	6.9	5.5	4.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: Calculated by Bureau of Economic Research and Statistics from data in table 1.

TABLE 3.—PERCENTAGE OF TOTAL CONSUMER EXPENDITURES SPENT FOR SPECIFIED ITEMS OF HEALTH CARE, 1935 TO 1973

Item	1973	1972	1971	1970	1969	1968	1966	1964	1962	1960	1958	1954	1950	1940	1935
Dentists	0.61	0.63	0.64	0.70	0.68	0.65	0.65	0.65	0.64	0.62	0.64	0.60	0.50	0.59	0.54
Physicians	2.06	2.09	2.13	2.10	1.98	1.87	1.80	1.76	1.69	1.63	1.58	1.42	1.34	1.29	1.31
Other professional services	.36	.36	.33	.33	.32	.34	.34	.31	.30	.30	.29	.26	.25	.25	.27
Drug preparations and sundries	1.07	1.10	1.09	1.12	1.11	1.09	1.10	1.08	1.13	1.11	1.10	.91	.90	.90	.85
Ophthalmic products and orthopedic appliances	.25	.25	.25	.28	.30	.32	.34	.26	.25	.23	.23	.25	.25	.26	.24
Privately controlled hospitals and sanitariums	2.85	2.82	2.81	2.73	2.53	2.30	1.99	1.93	1.72	1.57	1.45	1.22	1.04	.74	.73
Health insurance	.59	.60	.49	.42	.48	.47	.47	.44	.47	.42	39	.43	.32	.23	.17
Total	7.79	7.85	7.75	7.68	7.39	7.04	6.68	6.43	6.20	5.88	5.68	5.09	4.60	4.26	4.11

Source: Calculated by Bureau of Economic Research and Statistics from data published in Survey of Current Business, U.S. Department of Commerce (various issues).

TABLE 4.—PRICE INDEXES FOR ITEMS OF MEDICAL CARE AND CONSUMER PRICE INDEX, 1935 TO 1973

[1967=100]

Item	1973	1972	1971	1970	1969	1968	1966	1964	1962	1960	1958	1954	1950	1940	1935
Dentists' fees [1]	136.4	132.3	127.0	119.4	112.9	105.5	95.2	89.4	84.7	82.1	78.6	72.3	63.9	42.0	40.8
Fillings, adult, amalgam, 1 surface	138.7	133.8	128.0	120.3	113.1	105.4	94.7	88.8	84.3	81.9	78.2	72.0	63.9	42.1	40.4
Extractions, adult	135.4	132.2	126.9	118.6	112.9	105.2	96.7	90.4	85.0	82.0	79.0	72.6	62.8	40.3	39.5
Physicians' fees [2]	138.2	133.8	129.8	121.4	112.9	105.6	93.4	85.2	81.3	77.0	67.7	63.2	55.2	39.6	39.2
Family doctor, office visits	139.5	134.8	131.4	122.6	113.3	105.8	92.7	84.1	80.0	75.9	72.1	63.7	54.9	39.1	38.8
Family doctor, house visits	141.7	136.7	131.0	122.4	114.5	106.5	93.5	84.1	79.7	75.0	70.1	58.8	52.9	39.6	39.1
Obstetrical cases	138.1	133.8	129.0	121.8	113.5	105.2	93.0	87.1	83.7	79.4	75.5	64.4	51.2	33.0	32.1
Tonsilectomy and adenoidectomy	132.8	129.9	125.2	117.1	110.3	104.9	94.9	88.4	83.8	80.3	74.3	67.4	60.7	41.5	41.8
Examination, prescription, and dispensing of eyeglasses	129.5	124.9	120.3	113.5	107.6	103.2	95.3	90.9	89.2	85.1	82.1	75.9	73.5	58.1	56.6
Hospital daily service charges [3]	176.5	170.4	160.8	143.9	127.9	113.2	84.0	72.4	64.0	56.3	49.9	39.6	28.9	12.7	11.9
Semiprivate room	182.1	173.9	163.1	145.4	128.8	113.6	83.5	71.9	65.3	57.3	51.2	40.6	30.3	13.7	12.8
Drugs and prescriptions	105.9	105.6	105.4	103.6	101.3	100.2	100.5	100.5	101.7	104.5	102.8	93.7	88.5	70.8	70.7
Prescriptions	100.5	100.9	101.3	101.2	99.6	98.3	101.8	103.1	107.1	114.9	113.1	100.2	92.6	66.2	65.4
All medical care	137.7	132.5	128.4	120.6	113.4	106.1	93.4	87.3	83.5	79.1	73.2	63.4	53.7	36.8	36.1
Consumer Price Index	133.1	125.3	121.3	116.3	109.8	104.2	97.2	92.9	90.7	88.6	86.6	80.5	72.1	42.0	41.1

Source: Consumer Price Index (various reports), Bureau of Labor Statistics, U.S. Department of Labor.

[1] Indexes since 1963 include complete upper dentures.
[2] Included "appendectomy" before 1963.
[3] Formerly listed as "hospital rates" (before 1963) and included "men's pay ward."

TABLE 5.—PERCENTAGE CHANGE IN PRICE INDEXES FOR ITEMS OF "MEDICAL CARE" AND FOR CONSUMER PRICE INDEX FOR SPECIFIED PERIODS

Item	1972–73	1970–73	1958–73	1950–73	1935–73
Dentists' fees [1]	3.1	14.2	73.5	113.4	234.3
Fillings, adult, amalgam, 1 surface	3.7	15.3	77.4	117.0	243.3
Extractions, adult	2.4	14.2	71.4	115.6	242.8
Physicians' fees [2]	3.3	13.8	104.1	150.4	252.6
Family doctor, house visits	3.5	13.8	93.5	154.1	259.5
Family doctor, house visits	3.7	15.8	102.1	167.9	262.4
Obstetrical cases	3.2	13.4	82.9	169.7	330.2
Tonsillectomy and adenoidectomy	2.2	13.4	78.7	118.8	217.7
Examination, prescription, and dispensing of eyeglasses	3.7	14.1	57.7	76.2	128.8
Hospital daily service charges [3]	3.6	22.7	253.7	510.7	1,383.2
Semiprivate room	4.7	25.2	255.7	501.0	1,322.7
Drugs and prescriptions	.3	2.2	3.0	19.7	49.8
Prescriptions	—.4	—.7	—11.1	8.5	53.7
All "medical care"	3.9	14.2	88.1	156.4	281.4
Consumer Price Index	6.2	14.4	53.7	84.6	223.8

[1] Indexes since 1963 include complete upper dentures.

[2] Included "appendectomy" before 1963.

[3] Formerly listed as "hospital rates" (before 1963) and included "men's pay ward."

Source: Calculated by Bureau of Economic Research and Statistics from data in table 4.

TABLE 6.—CONSUMER EXPENDITURES FOR SELECTED ITEMS, 1973

Item	Amount (millions)	Percent total consumer expenditures
Tobacco products	$13,567	1.68
Alcoholic beverages	21,501	2.67
Recreation	52,280	6.49
Radio and television receivers, records, and musical instruments	12,920	1.60
Admissions to spectator amusements	2,898	.36
Parimutuel net receipts	1,325	.16
Personal care	12,315	1.53
Toilet articles and preparations	7,820	.97
Barbershops, beauty parlors, and baths	4,495	.56
Jewelry and watches	4,914	.61
User-operated transportation	102,621	12.74
New cars and net purchases of used cars	50,039	6.21
Gasoline and oil	28,307	3.52
Funeral and burial expenses	2,472	.31
Health care	62,726	7.79
Physicians	16,620	2.06
Dentists	4,901	.61
Hospitals and sanitariums	22,940	2.85

Source: Amounts from "Survey of Current Business," July 1974, US Department of Commerce, p 24. Percentages calculated by Bureau of Economic Research and Statistics.

TABLE 7.—EXPENDITURES AND PRICE INDEX FOR DENTAL CARE AND MEASURE OF RELATIVE AMOUNT OF DENTAL SERVICE RECEIVED PER CAPITA, 1935 TO 1973

Year	Estimated civilian population, July 1	Consumer expenditures for dental care (millions)	(A) Per capita expenditures for dental care	(B) Dental care price index (1967=100)	Amount of dental care per capita (A)—(B)/100
1973	208, 087, 000	$4, 901	23. 55	136. 4	17. 26
1972	206, 457, 000	4, 609	22. 32	132. 3	16. 87
1971	204, 250, 000	4, 312	21. 11	127. 0	16. 62
1970	201, 718, 000	4, 293	21. 28	119. 4	17. 82
1969	199, 145, 000	3, 921	19. 69	112. 9	17. 44
1968	197, 113, 000	3, 461	17. 56	105. 5	16. 64
1966	193, 420, 000	2, 970	15. 36	95. 2	16. 13
1964	189, 141, 000	2, 623	13. 87	89. 4	15. 51
1962	183, 677, 000	2, 265	12. 33	84. 7	14. 56
1960	178, 140, 000	2, 007	11. 27	82. 1	13. 73
1958	172, 226, 000	1, 876	10. 89	78. 6	13. 85
1954	159, 695, 000	1, 428	8. 94	72. 3	12. 36
1950	150, 790, 000	962	6. 38	63. 9	9. 98
1940	131, 658, 000	419	3. 18	42. 0	7. 57
1935	127, 099, 000	302	2. 38	40. 8	5. 83

Note: Alaska and Hawaii included beginning in 1960.

Source: Population figures are from "Current Population Reports." series P-25. Bureau of the Census. U.S. Department of Commerce. Estimates of consumer expenditures are from "Survey of Current Business," U.S. Department of Commerce. Dental care price indexes are from various reports on the Consumer Price Index. Bureau of Labor Statistics. U.S. Department of Labor.

Exhibit 20

INDEX OF DENTISTS' FEES, PROFESSIONAL EXPENSES AND SALARY EXPENSES, 1967–74, AVERAGE ANNUAL INDEX (1967=100)

Year	Dentists' fees [1]	Dentists' professional expenses [2]	Dentists' salary expenses [2]
1967	100. 0	100. 0	100. 0
1968	105. 5	110. 3	112. 5
1969	112. 9	121. 1	126. 6
1970	119. 4	131. 9	143. 4
1971	127. 0	149. 3	159. 9
1972	132. 3	166. 8	179. 2
1973	136. 4	186. 3	199. 8
1974	146. 8	208. 1	222. 7

[1] Source, Consumer Price Index, U.S. Bureau of Labor Statistics.
[2] Source, ADA Survey of Dental Practice, 1967, 1970, 1972. Estimated for nonsurvey years.

ESTIMATED INDEX OF DENTISTS' PROFESSIONAL EXPENSES, BY ITEM, 1974, AND ITEMS AS PERCENTAGE OF TOTAL EXPENSES

Item	Estimated 1974 index (1967=100)	Percent of total expenses
Office rent and utilities	183. 5	12. 3
Salaries (including commissions)	222. 7	32. 4
Fringe benefits (not included in salaries)	320. 5	1. 8
Dental supplies and equipment (excluding office supplies)	175. 4	17. 6
Commercial dental laboratory charges	167. 9	19. 9
Insurance, depreciation, travel, subscriptions, professional fees, etc	159. 3	3. 4
All other overhead (laundry, office supplies, postage, collection expense, office maintenance, etc.)	227. 5	12. 6
Total expenses	208. 1	100. 0

Source: ADA surveys of dental practice.

EXHIBIT 21

CONSUMER PRICE INDEX, U.S. AVERAGES FOR SELECTED ITEMS, 1950–75, AVERAGE ANNUAL INDEX (1967=100)

Year	Dentists' fees	Physicians' fees	Medical care	Semiprivate room rates	Services	All items
1950	63.9	55.2	53.7	30.3	58.7	72.1
1951	66.4	57.3	56.3	33.5	61.8	77.8
1952	67.8	59.8	59.3	36.6	64.5	79.5
1953	70.0	61.4	61.4	38.6	67.3	80.1
1954	72.3	63.2	63.4	40.6	69.5	80.5
1955	73.0	65.4	64.8	42.3	70.9	80.2
1956	74.4	67.4	67.2	44.9	72.7	81.4
1957	76.2	70.3	69.9	48.4	75.6	84.3
1958	76.6	72.7	73.2	51.2	78.5	86.6
1959	80.5	75.1	76.4	53.6	80.8	87.3
1960	82.1	77.0	79.1	57.3	83.5	88.7
1961	82.5	79.0	81.4	61.1	85.2	89.6
1962	84.7	81.3	83.5	65.3	86.8	90.6
1963	87.1	83.1	85.6	68.6	88.5	91.7
1964	89.4	85.2	87.3	71.9	90.2	92.9
1965	92.2	88.3	89.5	75.9	92.2	94.5
1966	95.2	93.4	93.4	83.5	95.8	97.2
1967	100.0	100.0	100.0	100.0	100.0	100.0
1968	105.5	105.6	106.1	113.6	105.2	104.2
1969	112.9	112.9	113.4	128.8	112.5	109.8
1970	119.4	121.4	120.6	145.4	121.6	116.3
1971	127.0	129.8	128.4	163.1	128.4	121.3
1972	132.3	133.8	132.5	173.9	133.3	125.3
1973	136.4	138.2	137.7	182.1	139.1	133.1
1974	146.8	150.9	150.5	201.5	152.0	147.7
1975 (January to August average)	160.1	166.4	166.2	231.1	164.4	159.3
Percentage increase 1950–75	150.5	201.4	209.5	662.7	180.1	120.9

Source: U.S. Bureau of Labor Statistics.

EXHIBIT 22

PRODUCTIVITY INDEXES OF INDEPENDENT DENTISTS IN 1970 BASED ON GROSS INCOME WITH FEE DIFFERENCES REMOVED BY COMPOSITE FEE INDEX, ACCORDING TO NUMBER AND TYPE OF AUXILIARIES EMPLOYED

Number and type of auxiliaries	Mean gross income	Mean composite fee	Composite fee index	Amount[1] of dental care provided	Productivity index
No employees	$28,793	$954.0	92.50	$31,128	100.0
1 part time assistant	31,785	969.0	93.95	33,832	108.7
1 full time assistant	40,252	979.0	94.92	42,406	136.2
1 full time assistant, 1 part time assistant	48,342	1,069.0	103.65	46,640	149.8
1 full time assistant, 1 part time hygienist	50,570	1,032.0	100.06	50,540	162.4
1 full time assistant, 1 full time secretary	57,503	1,028.0	99.67	57,693	185.3
1 full time assistant, 1 full time hygienist	62,232	1,047.0	101.51	61,306	196.9
2 full time assistants	60,828	1,013.0	98.22	61,930	199.0
1 full time assistant, 1 full time secretary, 1 part time hygienist	66,522	1,098.0	106.46	62,485	200.7
1 full time hygienist, 1 full time assistant, 1 full time secretary	97,094	1,072.0	103.94	76,096	244.5
5 or more full time auxiliaries, 0, 1 or more part time	115,209	1,126.0	109.17	105,532	339.0
All independent dentists	59,325	1,031.4	100.00	59,325	190.6

[1] "Amount of dental care provided" is what mean gross income would have been if fees had been equal to the national average. It is calculated by dividing actual mean gross income by the composite fee index.

Source: Data on gross incomes and composite fees are from "The 1971 Survey of Dental Practice," conducted by the Bureau of Economic Research and Statistics, American Dental Association.

Exhibit 23

Dental Manpower Growth

Total dental school enrollment:	
1964–65	13, 876
1969–70	16, 008
1974–75	20, 146
Total increase from 1964 (percent)	51
Projected increase in the number of dentists:	
1975	110, 000
1980	125, 500
Percent:	
Average annual increase through 1980	2. 8
Total increase through 1980	14
Projected increase in population:	
1975	215, 872, 000
1980	230, 955, 000
Percent:	
Average annual increase through 1980	1. 4
Total increase through 1980	7
Productivity	
Ratio of auxiliaries to dentists 1973:	
Hygienists	21 per 100
Assistants	110 per 100
Laboratory technicians	30 per 100

Dr. Kunkel. I would also like to submit a written statement on behalf of the Delta Dental Plans Association which through its member plans administers a large number of private and public dental prepayment programs throughout the country.

Mr. Cotter. Without objection, so ordered.

[The prepared statement referred to follows:]

Statement of the Delta Dental Plans Association

The Delta Dental Plans Association appreciates this opportunity to prepare a statement for view by this subcommittee.

The Delta Dental Plans Association is the national coordinating agency for the nation's dental society-sponsored, not-for-profit service corporations. which was created by an act of the House of Delegates of the American Dental Association in 1965.

The object of the Delta Dental Plans Association is to increase the availability of dental services to the public by encouraging the expansion of dental prepayment programs administered through dental society-approved dental service corporations, and by providing the means for active or associate members to cooperate with the Association in providing multistate and national group coverage.

The Delta Dental Plans Association is incorporated in the State of Illinois as a not-for-profit trade association.

At present the membership of the Delta Dental Plans Association is a follows: Active Member Plans 38, Associate Member Plans 2, Constituent Society Members 28, Affiliate Members 4.

The Delta Dental Plan system of dental service corporations, which have been formed in 47 of the 50 United States and the District of Columbia, today covers approximately 11 million people under both private and publicly funded dental care programs. Delta Dental Plans, as part of the historic tradition of provider-sponsored service plans, reflects the social concerns of its sponsoring profession. As such, the Association is aware that for a good many years, dental health care has been the "step child" of the health care field in the United States. Today, however, this picture is rapidly changing as dental care becomes more and more important in the eyes of Americans as part of the maintenance of good general overall health.

Today, nearly 30 million Americans have some form of dental care coverage under group health programs.

Little more than a decade ago, there were only a few thousand people in a handful of states that had this protection for themselves and their families. In the coming decade, it has been estimated that 75–100 million Americans will begin receiving dental care benefits through their employee group health programs.

Once though "uninsurable", dental care is already joining hospital and medical and surgical coverage as a standard benefit in the employee health care "package." As protection against the cost of the more catastrophic forms of illness has become more widespread, the interest of purchasers has turned to other high priority health care services such as dental care.

In any study of the history in the United States of providing dental care benefits on a prepaid basis, it should be noted that there was no significant activity in this area by the commercial insurance industry until that period in the mid-1960's when the pioneering efforts of the dental society-sponsored service corporations had proved the underwriting "safety" of prepaid dental care through experience and trial-and-error activity over a decade.

Dental care programs, because of their high utilization by employees and their families, have proven their value as a significant health service. Analysis of dental care programs has demonstrated that employees and dependents appreciate and use their dental care benefits. In many instances, the existence of a dental prepayment program has enabled a subscriber and his family to seek and receive adequate care for conditions previously neglected for financial reasons. Unlike other forms of health care coverage, dental care benefit programs can be used at once, and frequently.

Prepaid dental care programs, as offered today in the private health care sector, differ in many ways from traditional hospital and medical care coverage.

This is because dental disease, aside from existing in everyone, is also cumulative in its effect. Continued dental neglect inevitably leads to tooth decay and diseases of the gums and supporting tissues to loss of natural teeth and other oral complications.

Well conceived and effective dental prepayment programs will, therefore, stress two important factors: (1) they will provide benefits that will include all necessary services for the eradication of existing dental disease; (2) they will include benefits that emphasize prevention of dental disease, thereby keeping the subscriber's oral health at a routine maintenance level once dental disease has been eradicated.

More than twenty years ago, the American Dental Association and individual state dental societies, aware of the massive amount of dental care needed by the American public, began encouraging the formation of dental care prepayment Plans to provide group programs in the various states. Since then, dental societies in nearly every state have taken steps to obtain the necessary legislation to incorporate and activate dental service Plans.

These Plans, which adopted the "Delta Dental Plan" name and symbol, are presently underwriting or administering dental care programs covering approximately 11 million people.

Delta Dental Plans are independent, not-for-profit service corporations, formed and endorsed by organized dentistry to bring the benefits of better dental health to the American public.

While formed and sponsored by state dental societies, dental service corporations are separate prepayment organizations under the jurisdiction and regulation of state insurance commissions or attorneys general. As such, Delta Plan boards of directors are highly cognizant of their multiple responsibilities to program purchasers and subscribers in addition to the providing dentists who have contracted to deliver care under the terms of Plan programs. Evidence of this concern can be seen in the composition of Delta Plan boards, most of which include substantial lay and consumer representation.

Delta Dental Plans, as a result of their direct endorsement by the dental profession and their unique contractual relationship with dentists in private practice, provide "service" benefits to covered subscribers in contrast to indemnity dollars or fee schedule payments to cover the cost of care.

Delta Dental Plans design their programs to provide maximum dental care benefits at reasonable cost. No portion of the Delta income dollar is held for dividends to shareholders. All funds received by Delta Dental Plans are used to pay for services rendered to covered subscribers and their dependence and for administration of the program.

These unique characteristics of the Delta Dental Plan System have captured the interest and attention of informed purchasers in private industry and the international labor unions, as well as governmental agencies at the local, state and federal levels. There is a reason for this: Delta Dental Plns, as provider-sponsored service Plans, have demonstrated that, both on an intrastate and multistate basis, delivery of dental care programs covering all of the basic services necessary to eliminate and prevent dental disease could be available. In addition, Delta Plans make available on an optional basis, prosthetic and orthodontic services.

Moreover, the Delta system successfully pioneered the "usual, customary and reasonable" fee concept based on filed fee profiles of participating dentists which, in effect, guarantee that a greater proportion of the patient's treatment costs would be covered by a Delta Plan than any other form of prepayment.

The Delta Plan system has held as its guiding principle the provision of program benefits meeting the accepted definition of the dental profession for necessary care, i.e., benefits that stress preventive care and eradicate existing dental disease. This includes examinations and diagnosis, prophylaxis (cleaning), endodontic (root canal), periodontic, restorative, and oral surgical services.

In addition to these basic services, Delta programs also offer prosthodontic service (bridges, full and partial dentures), and orthodontic services in order to make possible a full scope dental care program.

Rather than offer selected benefits on a piece-meal basis, Delta Plans prefer to provide the widest possible scope of benefits to subscribers on a service basis, introducing, where necessary, such cost-sharing mechanisms as annual maximums, copayment factors or low-level deductibles in order to keep program rates within the resource capability of the buying organization.

It should be stressed, too, that Delta Plan administrative techniques, which have evolved from a first-hand awareness of the "elective" character of most dental treatment, embody a cost containment philosophy most visible in the determination of covered benefits by Plan dental directors and consultants.

Basing their claims processing policies on professionally accepted standards of dental care, Plan professional supervision personnel are able to control effectively areas of program over-utilization, and potential abuse, thereby exercising a level of cost-effectiveness in program administration not presently available from other carrier entities.

In addition to serving millions of Americans as the administrator or underwriters of dental care programs for corporate employees and union members and their dependents, the Delta Dental Plan system has also been responsible for the administration and delivery of care to eligible recipients of public assistance under a variety of tax-supported health care programs.

For many years, the Delta system has been the fiscal intermediary for numerous publicly funded programs throughout the country which have made possible the delivery of needed dental care in the private office setting, without necessitating the expenditure of tax dollars for the construction of costly clinical facilities in order to serve this segment of the public.

Delta Dental Plans in some 23 states are covering nearly 4½ million people for dental benefits under state and local programs ranging from Title XIX (Medicaid) to Job Corps, Project Head Start and Community Action Programs.

In terms of size, the Veterans Administration Program (29,000) and the Denti-Cal Program (Title XIX—2.4 million people) administered by California Dental Service, largest of the Delta Plans, represent the most dramatic example of how a not-for-profit service Plan can utilize the resources of the private sector in providing care to those covered under government programs. Close to $70 million has been paid by CDS for necessary dental services rendered to covered beneficiaries of both programs in each of the past years.

The Denti-Cal Program has been the subject of close observation by many state and federal agencies including the Department of Health, Education and Welfare with respect to its potential as a model for future cooperative ventures between the private prepayment sector and government in the delivery and financing of needed health care.

Certainly the statistics generated by the Denti-Cal Program in the past two years have been impressive. For example, after CDS took over the administration of the program from the state, the percentage of claims requiring prior authorization dropped from 85% to 15%—eliminating an enormous and costly clerical workload without compromising the cost or quality of services delivered.

In the first year of its operation under CDS, utilization of benefits by eligible recipients increased by % for adults and 40% for children—with utilization by children in the critical 6 to 12 year age category increasing by 47%.

The increased cost efficiency of the Denti-Cal program has been frequently cited. The program is being operated by CDS with an administrative cost of less than 6%. In other words 94¢ of every Denti-Cal dollars received by CDS is expended for actual dental care for the eligible recipients. This is far more actual dollar benefits than could be financed and administered by any other private or public agency.

In 1973, the State of California spent $58 million for dental care services for its medically indigent population. This amount increased to $69 million in 1974 and is projected to reach $74 million in 1975. Estimates for 1976 costs are approximately $83 million.

In general, the CDS administered Denti-Cal program has been proven to be an excellent example of how more care can be delivered to increasing numbers of individuals, with the cooperation of providers, and with the result that increased dollars are expended for care and less for administration.

The Delta Dental Plans Association also wishes to call the attention of the Committee to the fact that a number of the prominent National Health Insurance proposals contain provision for approval of potential carriers on the basis of their previous experiences in providing hospital, medical and other health care coverage. Such limitations would obviously preclude consideration of the dental service corporation system, inasmuch as Delta Plans, as single line carriers, do not have a "track record" in other forms of health care coverage.

These standards are patently illogical and unfair in that they would automatically exclude consideration of the one dental prepayment carrier system that has the longest experience in providing this coverage—and which presently covers nearly 40 percent of all Americans with some form of prepaid dental care benefits!

Dental care prepayment, by virtue of the near universality of dental disease, as well as the elective nature of dental treatment, differs greatly from other forms of health care prepayment and insurance. Guidelines affecting carriers for a dental portion of any national health insurance program should reflect these distinctions if they are to be truly effective.

To summarize, the Delta Dental Plans Association would like to reiterate the following points as they relate to the unique characteristics of the dental service corporation system:

More than 20 years of experience in providing prepaid dental care benefits under both private and publicly funded programs. Delta Plans now cover 4 out of every 10 Americans who have dental care coverage,

Programs based on true "service benefits".

A reliable and inflation-minimizing payment system to providers based on verified "usual, customary and reasonable" fee fillings.

Programs that stress preventive benefits, reducing the need for the more extensive and more costly dental procedure.

Predetermination procedures to protect patients from unanticipated charges.

Professional supervision of claims to assure quality care.

Post-treatment screening of completed cases to assure treatment at professionally acceptable levels.

Minimal paperwork for patient and administrator.

A not-for-profit system with all funds used exclusively for the payment of benefits and operating costs.

Multistate and national capability. Presently administering more than 40 national and multistate programs for employees and their dependents of major American corporations.

In conclusion, the Delta Dental Plans Association wishes to express its appreciation for the opportunity to submit this statement concerning this important area of health care financing and delivery. Our organization wishes to reaffirm, for the record, its complete support of the policies and positions of the American Dental Association with respect to national health insurance proposals.

The Delta Dental Plans Association also wishes to express its willingness to provide any additional information to Committee members and staff with respect to any material covered in this statement.

Dr. Kunkel. I will attempt now to summarize as briefly as possible our basic position and concerns regarding national health insurance legislation.

In designing a dental component of a national health insurance program we would offer the following principles:

Public funds should be concentrated exclusively on those who are needy or medically needy;

Administration of the program should be located within the private sector;

The usual and customary fee concept should be the preferred reimbursement mechanism; and

Licensed dentists representative of the majority of dental practitioners in any given area should provide the review necessary to determine the quality and appropriateness of dental services.

The essential place of dental care in any program of comprehensive health care is obvious. I believe everyone seriously concerned with the delivery of health care concurs in this. Virtually all of the proposals before you include provisions for children's dental care. This is fully consonant with the profession's long-standing recognition that preventive dental care, undertaken in childhood, is a priority that is essential to any concerted effort to control dental disease and prevent many of its occurrences.

There are certain inherent differences between the delivery of dental and medical care which should be taken into consideration in drafting national health insurance legislation. They result from a number of factors, important among them being the universality of dental disease and, at the same time, the degree to which it can be controlled by relatively straightforward action. No plan can succeed that does not take fundamental account of this factor. We are most hopeful that the committee will keep this firmly in mind as it goes forward with its planning.

In addition to the inclusion of comprehensive dental care for children, the profession believes that any national health insurance program should provide emergency dental services for those individuals not covered under the comprehensive program. A description of emergency dental services and cost estimates are included in exhibits 3 and 4.

If because of fiscal restraints it should become necessary to defer the inclusion of some children in the comprehensive program, we would advise that a progressive schedule be developed to phase children into the program in age-group increments. Cost estimates for various age groups and income levels are included in exhibits 1 and 2.

More fundamental than any of these foregoing matters, Mr. Chairman, is dentistry's conviction that a national health insurance program, including its dental component, be based upon the existing system of delivery.

Throughout the debate over a national health insurance program there has been a theme repeatedly voiced by some that the existing delivery system is so deficient as to be an unacceptable foundation for the future. While fully crediting the honest intentions of those who make the charge, we reject it. We believe, on the contrary, that there is overwhelming evidence of the existing systems' basic viability. Certainly it should not be discarded in favor of a monolithic, untested scheme of the sort that has failed to meet expectations in other countries.

Last year under our present system some 115 million people received dental care. We believe the care they received was of high quality and was provided at a fair cost and in a reasonably accessible manner. It is our contention that this happens not in spite of the system, but precisely because of it.

The efficiency of the present system in establishing and maintaining relatively moderate dental fees over the past 25 years may be seen in a review of the Consumer Price Indexes for that period, which have been submitted for the record (exhibit 21).

Substantial progress has been made in increasing dental manpower and in intensifying the productivity of the individual dental office (exhibit 22). Markedly more sophisticated measures of productivity and demand are now under development through the initiative of private as well as public research agencies. One of our foremost goals in helping to provide the considerable resources necessary for such research is the accurate identification of problems such as dentist shortage areas, so that they may be corrected in an expeditious and rational way.

The traditional system for providing dental services also continues to demonstrate its ability to accommodate a variety of dental prepayment programs. This, we think, is no small accomplishment. The number of beneficiaries of some form of dental prepayment has quadrupled since 1970 and the vast majority of the nearly 30 million people now receiving benefits do so in the private office setting.

It was, to a large extent, the dental profession itself that took the first steps some 20 years ago in fostering dental prepayment through dental plans which are private, nonprofit service plans. These plans, represented by the Delta Dental Plans Association, provide benefits to some 40 percent of those covered by prepayment. The accumulated experience of these plans should be fully utilized in any future program and legislative draftsmen should be careful to assure that applicable definitions do not exclude them.

Concurrent with this growth of dental prepayment has been the profession's development of sound, viable, and impartial peer review mechanisms, designed to insure the quality of care being delivered to all patients, the insured and uninsured alike.

With respect to cost increases that might be anticipated, the evidence is that in the period 1950–75 dental fees increased less than service costs generally, medical care costs, physician fees or hospital costs. This occurred during a period when dental prepayment moved from a nonexistent status to a coverage of 28 million people. From 1967 through 1974 dental fees increased on the CPI index basis from 100 to 146.8 while dental professional expenses increased on the same index from 100 to 208.1 and dentists' employee salaries from 100 to 222.7.

With respect to dental manpower, between 1950 and 1974 first year enrollment in dental schools increased from 3,226 to 5,617, an increase of nearly 70 percent. While dentist-to-population ratio is an inexact measurement device, and the association presently is working toward better measurement tools, the ratio has been growing increasingly favorable.

With respect to increased productivity through the use of dental auxiliaries, enrollment in dental hygiene schools increased from 1964 through 1973 from 3,502 to 9,400; in dental assisting schools from 1,919 to 8,595. Increased productivity resulting from the employment of auxiliaries is indicated in exhibit 22.

With respect to public opinion regarding inclusion of dental care in private sector insurance arrangements a survey in 1972 under governmental auspices indicated that 90.7 percent of the respondents thought dental care should be included. When asked to choose between receiving services in a clinic or private office, 94 percent expressed a preference for the private office setting.

With respect to the progress that has been made in preventing dental disease, controlled comparative studies in Newburgh, N.Y. showed that 41 percent of 5- and 6-year-old children in a fluoridated community had no cavities while in the nearby, nonfluoridated community only 17 percent had no cavities.

Translated into annual cost of dental care per child, there was a cost of $16.93 in the fluoridated community compared with $40.78 in the nonfluoridated community.

A 1969 survey of individual services rendered showed, over a 19-year period, an increase in preventive services such as 454 percent for topical fluoride treatments, 124 percent for root canal therapy with, at the same time, a 6- to 7-percent decrease in extractions.

We recognize, Mr. Chairman, that the foregoing facts and statistics do not answer all of the questions that might be posed. We hope, however, that we have provided some information that will be helpful in your deliberations.

With respect to the existing major national health insurance proposals, we would offer the following general comments regarding their provisions relative to the association policies.

BENEFITS

Nearly all of the bills provide comprehensive dental care for children, thus endorsing the profession's long-held conviction that prevention is the key to controlling dental disease. The benefits for children as outlined in H.R. 6222, H.R. 1, H.R. 22, and H.R. 5990 are basically compatible with the association's policy.

In this connection it should be emphasized that if limitations are necessary, they should be in terms of the age groups of children covered rather than by a scaling-down of the comprehensive benefits offered. Only H.R. 6222 spells out specifically the emergency dental benefits that will be available. Under any program that might be enacted this deficiency should be corrected in accordance with the definitions that have been submitted for the record as part of exhibit 3.

Additionally, most of the bills are deficient in failing to recognize that there are services that can appropriately and legally be performed by either a dentist or a physician. We believe that in instances where the physician or the dentist is licensed to provide the service, it is inequitable both for the patient and the practitioner for Federal law to limit payment only to the physician.

By the same token, with respect to hospital admission by dentists and coverage of expenses associated therewith, existing laws such as medicare and medicaid as well as several of the pending proposals should be amended to assure that payment or reimbursement is not denied a patient where the hospitalization was necessary because of a dental or medical condition as certified by the attending practitioner, whether he is a dentist or physician.

I am sure that Dr. Slaughter of the American Society of Oral Surgeons will elaborate more on these points.

FINANCING

It is the position of the association that financing from public funds should be utilized only to assist persons who are unable to pay for health services themselves. The association also supports the use of deductibles and coinsurance except with regard to certain basic services such as periodic examinations, diagnosis, prophylaxis, topical fluoride applications, plaque control programs and emergency treatment.

The association is in strong opposition to a financing approach such as that proposed in H.R. 22 establishing a new payroll tax and its concomitant massive bureaucratic administrative structure. Preferable approaches are contained in H.R. 6222 and H.R. 5990 which would utilize the private sector for financing, thus continuing the competitive role of private carriers with funding from State and Federal general revenues for coverage of the needy and other high-risk categories of persons.

H.R. 1 would rely basically on the private sector for funding with public funds being utilized according to an individual's needs. The bill does, however, provide a preference in the form of a subsidy for a single system of health care delivery, the health care corporation. We are opposed to this approach.

ADMINISTRATION

The association believes that the role of the Federal Government in the administration and regulation of a national health plan should be minimal, with the primary responsibility for the administration of benefits and for cost and quality assurance activities being undertaken by the private sector.

H.R. 6222 and H.R. 5990 are compatible with the concerns of the association in this respect. We support the establishment of a separate department of health as proposed in H.R. 1, but, as indicated earlier, are opposed to the bill's singular reliance upon health care corporations, particularly with respect to the provision of noninstitutional health services.

H.R. 6222 does not rigidly specify the administrative procedures which would be developed except for establishing basic standards for acceptable programs. This would permit the continued utilization of the existing system allowing for flexibility and adaptability to new needs and innovations. The association opposes the provisions in H.R. 22 which would establish a massive and unnecessary administrative structure and regulatory mechanism with final authority over all health care matters.

OTHER COMMENTS

The association would like to offer a few comments on H.R. 10028, the Catastrophic Health Insurance and Medical Assistance Reform Act. The association favors the standardization of benefits and eligibility provisions under medicaid, but believes H.R. 10028 should be made more specific: (1) in counting the expenses for dental services toward the deductible amount, and (2) in its inclusion of dental benefits for children and emergency dental care for others.

Similarly, the guidelines for certification of private health insurance should include the dental care coverage we have recommended—comprehensive children's benefits and emergency dental services for others.

We are sympathetic with the desires of the sponsors of H.R. 10028 to protect individuals and families against catastrophic health care expenses. However, we are not in favor of financing through a payroll tax and the use of a Federal agency for administration. The option which would be given to employers to purchase private catastrophic health insurance does not cure the defect in the basic thrust of this legislation establishing a federally financed and administered program.

Finally, Mr. Chairman, the association testified a few weeks ago in opposition to the provisions of the Professional Standard Review Organization program which do not provide an explicit role for dentists in all phases of the review process dealing with dental services. The association requests that this matter be given attention by the committee both in relation to existing health care programs under the social security law and future legislation.

Mr. Chairman, this concludes my testimony. Mr. Bishop and I would be glad to answer any questions.

Mr. COTTER. Thank you very much, Doctor. We will go on with the panel, and then get to the questions.

Dr. Terkla, would you care to proceed, please?

STATEMENT OF LOUIS J. TERKLA, D.D.S.

Dr. TERKLA. Mr. Chairman and members of the subcommittee, I am Louis Terkla, dean of the University of Oregon Dental School. Mr. Chairman, I am also president of the American Association of Dental Schools, and on behalf of the association, I would like to express our appreciation to the committee, and to the committee staff, for providing us with this opportunity to present our views on the critical subject of national health insurance.

For the sake of time, and with your permission, Mr. Chairman, I propose to limit my remarks to the dental priorities which we believe should be included in the planning and design of a national health insurance program and to considerations which will be necessary to assure that adequate numbers of quality dental providers are available.

The American Association of Dental Schools supports the development of a national health insurance program that includes dental components which serve the needs of all people. We believe that such a program should begin at the same time any national health insurance program is initiated. We also support the use of public funds to meet the cost of care for persons who are financially unable to do so themselves.

In our view such a national program should include the following elements:

1. Comprehensive dental services for children should have the highest dental priority in any national health insurance program. Should any phasing-in of services be necessary, coverage should be scheduled to enroll successive age groups, beginning with the youngest age feasible.
2. There should be a provision for emergency dental care for all.
3. The program should be reviewed, at least biennially, and revised according to needs, experience, and resources available. Extension of coverage to include other age groups should be accomplished as soon as is feasible. However, expansion should not occur until those initially covered can be offered continued coverage.
4. Prime emphasis and first-dollar priority should be given to the prevention of dental disease through community and personal preventive practices. The program should include a comprehensive educational program to motivate people to practice good personal oral hygiene and to utilize available dental care to the fullest extent.

These then are the dental elements which we believe should be included in a national health insurance program. Additionally, we wish to point out two factors which will be critical to the success of any national program enacted.

We must determine what impact that program will have on manpower requirements, which is to say that we must predict more precisely than we have been able to do thus far, the numbers and kinds of health personnel who will be needed to implement a national program.

Once these true requirements have been determined, we must assure sufficient numbers of qualified health personnel are available now and in future years. If adequate manpower resources are not available, health care costs will escalate and we will simply be presenting to many Americans a health care system which, for them, is still not a reality.

We think that a national program should include designated funds to support the education and training of the health personnel needed to provide services available under that program. These so-called "front-end dollars" should be available to assist institutions in maintaining, developing, and, where necessary, expanding educational programs to meet the demands of a national health insurance program. Federal assistance should also be available to students in the form of direct loans and scholarships in return for agreements to practice in designated national shortage areas.

At the present time Federal support for the training of the health personnel is provided through a number of separate authorities which are in response to various national priorities. If a truly national health insurance proposal is to be enacted, serious thought must be given to more stable and more predictable sources of funding. The appropriate time to consider such an approach is during the deliberation of a national health insurance program.

Mr. Chairman, I hope I have not taken too much of the subcommittee's time. If it will assist the subcommittee, I would be pleased to submit a more detailed statement for inclusion in the record.

Thank you again for this opportunity.

[The detailed statement follows:]

AMERICAN ASSOCIATION OF DENTAL SCHOOLS

STATEMENT ON NATIONAL HEALTH INSURANCE [1]

The American Association of Dental Schools supports the development of a national health insurance program that includes dental components which serve the needs of all people and believes that a dental program should begin at the same time any national health insurance program is initiated. The Association also supports the use of public funds to meet the cost of care for persons who are financially unable to do so themselves.

The Association is convinced that any national health insurance program must include provisions for assuring the availability of sufficient health manpower to provide needed services, and that health professions educational institutions will need supplemental funds to maintain the capacity of existing programs. Further, the Association believes that support for the education and training of needed health personnel should be an integral part of a national health insurance program.

Priorities

The following priority guidelines are suggested in the planning and design of a national health insurance program.

1. Comprehensive dental services for children should have the highest dental priority in any national health insurance program. Should any phasing-in of services be necessary, coverage should be scheduled to enroll successive age groups, beginning with the youngest age feasible. Comprehensive dental services would be defined as periodic examination and diagnosis, including radiographs and detection of oral manifestations of systemic diseases; preventive procedures, including dental health education; elimination of infection and life-hazardous oral conditions (for example, oral cancer and cellulitis); severely handicapping malocclusions and congenital or acquired disfiguring oral deformities; treatment of injuries (for example, fractures of the facial skeleton and jaws); elimination of diseases of bone and soft tissue of the oral cavity and adjacent areas; treatment of anomalies; restoration of decayed or fractured teeth; maintenance or recovery of space between teeth when this service will affect occlusion; replacement of missing permanent teeth; treatment of malocclusion with priority for interceptive treatment and disfiguring and handicapping malocclusions.

2. There should be provision for emergency dental care for all. Emergency dental care would be defined as control of bleeding; control of life-hazardous oral conditions (for example, oral cancer and cellulitis); congenital disfiguring oral deformities; relief of pain; treatment of injuries to the teeth and supporting tissue (for example, fractures and dislodged or incompletely developed permanent teeth); elimination of major acute infection.

3. The program should be reviewed, at least biennially, and revised according to needs, experience, and the resources available. Extension of coverage to include other age groups should be accomplished as soon as feasible. However, additional groups should not be added unless those people initially covered by the program can be offered continued coverage.

4. Prime emphasis and first dollar priority should be given to the prevention of dental disease through community and personal preventive practices. The program should include a comprehensive educational program to motivate people to practice good personal oral hygiene and to utilize all available dental care benefits to the fullest extent.

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[1] This statement was approved by the executive committee in November 1975 and will be presented to the house of delegates, for adoption, at the association's next annual session in March 1976.

Education and training

A national health insurance program should provide support for the education and training of needed health manpower. The following guidelines are suggested for the development of this aspect of a national health insurance program.

1. A "front-end load," designated for the support of professional education and training, should be included in the allocation of funds. The funding agency should not exercise control over, or prescribe requirements with respect to, the curriculum, teaching personnel or administration of any program in any school, or the admission of students to any school or program.

    a. Support should be available to assist in meeting needs for the expansion, replacement, and renovation of existing educational facilities, and for the construction of new facilities.

    b. Institutional supplemental support should be available to dental and dental auxiliary schools to ensure maintenance of current enrollments and the continued fiscal viability of these institutions.

    c. Grants should be available to dental and dental auxiliary schools to explore, develop, and demonstrate improved methods of service delivery, effective use of dental auxiliaries, training away from campus, and other innovative projects.

    d. Grants should be available to establish and maintain formal training programs in the performance of expanded functions (consistent with dental practice acts) for auxiliaries who are already in the work force or who plan to return to the work force.

    e. Federal assistance should be available to dental students in the form of direct loans and scholarships in exchange for agreements to practice one year in a designated shortage area for each year of support, with a minimum commitment of two years of service.

    f. Grants should be available to assist new and existing residency programs in general dentistry and to provide stipend support for residents if needed.

    g. Monies from this fund should not be used to substitute for other non-federal income received by the school.

2. Dental schools and practitioners should provide greater emphasis on the teaching and practice of preventive procedures.

3. Continuing education or alternative methods of assuring competency should be required of every provider.

Research and studies

A comprehensive national health insurance program should have the authority to allocate funds for support of a program of research and studies to determine more effective and efficient ways to deliver dental services, to evaluate programs, to conduct long-term longitudinal studies of need, demand, and utilization of dental services, and to assess the quality and quantity of dental services and their affect on the nation's oral health status.

Delivery of services

The following guidelines for delivery of services are suggested in the development of a national health insurance program.

1. The program should be designed to assure ready accessibility of professional services at all times for the treatment of dental emergencies.

2. The program should encourage practice in underserved areas through financial incentives, including tax benefits and guaranteed loans for the establishment of dental practices.

3. A federal-state personnel system, such as a health service corps, should provide services where and for such time as the dental work force is insufficient to meet the demand for service.

4. While private practitioners should remain the primary source of dental care, hospitals, clinics, and educational institutions should be recognized as suitable providers, eligible for appropriate reimbursement.

5. Incentives (such as guaranteed loans for capital improvements, office overhead, and insurance protection) should be provided to encourage dentists to increase their productivity through the use of multiple auxiliaries.

6. Development of group practices should be encouraged through guaranteed loans and interest subsidies for capital investments.

Payment mechanisms

The following guidelines are suggested for payment mechanisms in the design and planning of a national health insurance program.

1. Various methods of reimbursement of dentists should be allowed and evaluated, so that the most efficient arrangements can eventually be determined by experience and by consumer choice. The mandating of capitation as the only system in a national health insurance program is not desirable. Private methods of reimbursement through the use of dental service corporations, insurance companies, and other private means should be encouraged.

2. Reimbursement, under any method, whether based on usual and customary fees, fixed fees, or institutional rates, should be realistic in relation to the cost of delivering dental services. Determination of fee arrangements, including verification, should be made at the state level.

3. Patient participation in paying for the costs of care should be through co-payment, rather than through deductibles.

4. Neither deductibles nor coinsurance should be applied to basic services, such as periodic examinations, diagnoses, prophylaxes, fluoride topical applications, plaque control programs, and emergency treatment.

5. Programs should be encouraged to provide incentives for the maintenance of dental health by reducing the patient's coinsurance at stated time intervals, provided he avails himself of necessary dental services on a regular basis.

Funding

The following guidelines for funding are suggested in the design and planning of a national health insurance program.

1. Budget assurance should be provided for mandated dental services.

2. Dental benefits for those unable to pay should be financed through federal revenues.

3. Dental benefits for the employed could be funded through payroll deductions with employer and employee contributions, possibly with additional employee participation in costs through co-payment or deductibles, or both. A parallel plan could be developed for self-employed persons.

Administration

The following guidelines on administration are suggested in the design and development of a national health insurance program.

1. Program administrators and planners should be sensitive to the differences that exist between the delivery of dental care and the delivery of other health services.

2. The dental component of a national health insurance program should be administered by groups experienced in the planning, operation, and evaluation of dental service programs.

3. A national dental advisory council should be authorized, consisting of individuals knowledgeable in the planning, design, operation, and evaluation of health care and resource development programs. Consumers should be represented.

Review procedures

The following guidelines are suggested for the development of review procedures in a national health insurance program.

1. Review of the dental components of a national health insurance program should be the responsibility of licensed dentists, but consumers should participate in the review process.

2. Review of the quality of dental services should be performed by licensed dentists and should include review for the reasonableness of procedures.

3. Appeal procedures and due process should be provided in all review procedures.

Mr. Cotter. Thank you very much, Doctor.

Dr. Clark, if you would, proceed next.

STATEMENT OF CHARLES A. CLARK, D.D.S.

Dr. Clark. I am Charles Clark, chief of dental health planning. Metropolitan Health Planning Corp., Cleveland, Ohio, and I would like to thank the chairman and members of this committee for inviting me to speak.

I will briefly discuss some of the problems of dental disease. I will suggest two methods that could aid in the solution of the problem, and will offer five recommendations for improved dental health through national health insurance.

PROBLEM

Dental diseases are generally considered to be the most common afflictions of mankind. The most common forms of dental disease are caries and periodontal disease.

Dental caries—sometimes called cavities or decay—are characterized by destruction of the hard or calcified parts of the teeth. Most teeth that are lost because of dental caries—approximately 40 percent—are lost between the ages of 15 and 24.

Periodontal disease—sometimes called pyorrhea—destroys the supporting structures of the teeth, the gingiva—gum—and bone. Most teeth lost from periodontal disease—approximately 50 percent—are lost after age 25.

Other diseases of the mouth include malocclusions, an abnormal relationship between the teeth of the upper and lower jaws; oral cancer, a destructive growth of cells in the mouth that may cause death; and oral clefts, a lack of fusion of bone and/or tissue around the mouth.

Even though dental disease is widespread, only 20 percent of the U.S. population visits the dentist twice during the year; another 20 percent once a year; and the remaining 60 percent only occasionally, if at all. Cost, lack of availability, lack of accessibility, lack of appreciation, and fear are among the reasons for sporadic visits to the dentist.

Although dental disease is not usually thought of in terms of life or death, it does impose measurable costs. In 1972, the American population experienced an estimated 20,013,000 days of restricted activities from dental disease. Of these, 7,831,000 days were spent in bed. A total of 3,473,000 days were lost because of dental disease in 1973 among the American labor, totaling 91,040,000 people. That same year, a total of $5,385 million was spent for dental treatment in the United States.

In 1973, 35,100,000 American children were enrolled in kindergarten through eighth grades. It has been estimated that the average daily absentee rate in schools is 10 percent. Thus, an estimated 351,000 pupils would be absent from school each day. Of these 351,000, 6 percent—or 21,060—are estimated to be absent each day because of dental disease. This figure does not include those children who are in school but who are inattentive due to discomfort.

Prevalence of disease may be reduced through such measures as prevention and treatment.

PREVENTION

The bromide "An ounce of prevention is worth a pound of cure" is especially appropriate for dental disease. Prevention here means the use of fluorides, programs in dental health education, and early visits to the dentist.

A classic epidemiological study during this century established fluorides as an effective agent in reducing dental caries, with a great margin of safety in terms of physiological processes.

The most effective method of fluoridation is by ingestion of one part per million fluoride through central drinking water. This method is effective in two ways. First, fluoridated drinking water leads to a caries-reduction rate of 60 percent, a rate higher than any other fluoridation method. Second, this method is implemented with mechanical ease and at low cost.

Currently, approximately 60 percent of the American population is receiving such benefits through fluoride in central drinking water supplies. Many reasons are given as to why the total population does not have fluoridated water, including inaccessibility of a central water supply. An alternative, then, would be to apply fluorides through the schools in such communities. The quantity of fluorides in school fluoridation projects should be greater than one part per million since school is in session only one-third of the day. But, in controlled studies, a significant caries reduction has been realized in these children with no harmful effects.

Where broad-scale ingestion may not be feasible, topical application is an appropriate alternative. These would be offered in addition to any methods used by private dentists. One approach is through the use of weekly fluoride mouth rinses by pupils in classrooms during the school year, such as a program just begun in Geauga County, Ohio. Such methods have significantly reduced dental caries.

Since fluoridation is an effective method to reduce dental caries, and since people in some unfluoridated areas have experienced staggering dental expenditures as noted in public assistance programs, an expedient cost-reducing measure would be to encourage fluoridation by returning treatment costs to States directly proportionate to its degree of fluoridation and other preventive measures.

Dental caries reduction through fluoridation requires no motivation at virtually no expense. Periodontal disease prevention, on the other hand, does require motivation to improve and/or maintain personal dental health habits, and to visit the dentist before neglected areas become problems.

It would be desirable if everyone had access to dentists who would provide dental health education. But, the 60 percent of the population who visit dentists occasionally are probably there only because of an acute need and are probably not receptive to preventive measures.

The 20 percent who visit once a year may be partially receptive, but the 20 percent who visit regularly would be the most receptive. The latter two groups are a minority of the population; therefore, a place is needed where prevention could be taught under more ideal teaching conditions, where reception would be better, and where a broader segment of the population would be reached—in the school system.

Preventive measures taught in the classroom would lead to reduction in both dental caries and periodontal disease. With structured programs in dental health education, incorporated into the total curriculum, pupils will develop personal dental health habits, reduce their fears of the dentist, learn the value of selection of noncariogenic foods, visualize the need for early and continued visits to the dentist, learn to exercise appropriate measures in case of dental accidents and emergencies, and learn how to enter the dental care delivery system. The Ohio program for dental health education in schools, administered by the Metropolitan Health Planning Corp. of Cleveland, is one such program.

TREATMENT

As health becomes a right, as financing mechanisms become more available, and as people become more aware of the need to improve their dental health by prevention and treatment, we can expect a greater demand for dental services.

The treatment of dental disease, however, rests with dentists, and they are free to practice where they wish. We have seen that even States that are big producers of dentists experience great dental manpower shortages. So, retention and distribution of dentists is very important.

An issue before Government, therefore, is to increase the availability and accessibility of services to those in need. Equitable distribution of dentists among those in need calls for realistic inducements to attract dentists to underserved areas. Such measures might include the encouragement of matching programs between dentists and specific communities, grants and/or tax reductions for practices in dental manpower shortage areas, and extensions of postgraduate training in smaller cities.

Increasing the manpower will provide only a partial response to the demand, however. Another practical measure is expanding the duties of dental auxiliaries. This means that dental auxiliaries should be delegated more responsibility under supervision of a dentist than has been usually done. Such a precedent has already been set in the medical profession has proven itself in the dental profession.

Provision of insured dental care to every American who wants it would be ideal. But costs may preclude such a monumental venture. In that case, I would suggest that care be provided to two categories of people with equal priority—children up to age 15, and senior citizens.

Children will have less accumulated dental disease than young adults or adults. If they receive incremental care—beginning as they enter school and maintaining it on a yearly basis under controlled conditions—the total costs will be less. An incremental program from the beginning would be more practical than a program to treat children who are victims of accumulated neglect.

Since children are required by law to attend school, the best controlled conditions would be to have dental treatment facilities in schools. Experience in other countries has shown, however, that when only treatment was provided in such controlled situation, the patient allows his dental health to revert miserably to an undesirable state when treatment stops. One must be motivated to maintain a healthy dental condition. Therefore, a strong program of dental health education in schools becomes mandatory.

At the other end of the age spectrum, we find the senior citizens, whose health may be failing. An adjunct to good health is a nutritious diet. An integral part of the utilization of a nutritious diet is a healthy mouth. This ofttimes forgotten or ignored segment of the population in many instances is forced to have extraction and dentures rather than encouraged to maintain natural teeth. Because this method seems on the surface to solve the problem, the elderly ofttimes becomes permanent dental cripples for their remaining years.

Dental services should be generally available to the elderly, and one place where this could be structured is through the Nation's network of certified extended care facilities.

SUMMARY AND RECOMMENDATIONS

I have brought to your attention that dental disease is virtually universal, that its costs extend deep into our pocketbooks, it robs the education of our children, and it reduces the Nation's goods and services. As knowledge and financing increase, we can expect the demand for dental services to increase. Though treatment demands will continue, the magnitude of treatment required would be reduced through universal fluoridation. Providing treatment services for all who demand it is expensive, and if priorities must be made, children and senior citizens should be considered first.

In an effort to improve the dental health of American citizens through national health insurance, I recommend:

1. Encouragement of the utilization of fluorides, both ingested and topically applied, through returns of treatment costs directly proportionate to States' fluoridation;
2. Provision for dental health education and treatment facilities for children in schools;
3. Promotion of the use of expanded duties of dental auxiliaries;
4. Encouragement of dentists to work in manpower shortage areas; and
5. Provision of care for senior citizens generally, and specifically in extended care facilities.

Thank you for this opportunity.

[The prepared statement follows:]

IMPROVEMENT OF THE NATION'S DENTAL HEALTH THROUGH NATIONAL HEALTH INSURANCE[1]

(By Charles A. Clark, DDS, MPH[2])

Thank you, Mr. Chairman and members, for inviting me to speak before this Subcommittee on Health of the House Ways and Means Committee. I will briefly discuss some of the problems of dental disease. I will suggest two methods that could aid in the solution of the problem, and will offer five recommendations for improved dental health through National Health Insurance.

Problem

Dental diseases are generally considered to be the most common afflictions of mankind. The most common forms of dental disease are caries and periodontal disease.

Dental caries—sometimes called cavities or decay—are characterized by destruction of the hard or calcified parts of the teeth. Most teeth that are lost because of dental caries—approximately 40%—are lost between the ages of 15 and 24.

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Other diseases of the month include malocclusions, an abnormal relationship between the teeth of the upper and lower jaws; oral cancer, a destructive growth of cells in the mouth that may cause death; and oral clefts, a lack of fusion of bone and/or tissue around the mouth.

Even though dental disease is widespread, only 20% of the United States population visits the dentist twice during the year; another 20% once a year; and the remaining 60% only occasionally, if at all. Cost, lack of availability, lack of accessibility, lack of appreciation, and fear are among the reasons for sporadic visits to the dentist.

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[1] Presented on Nov. 18, 1975, as testimony before the Subcommittee on Health, Committee on Ways and Means, United States House of Representatives.

[2] Dr. Clark is Chief of Dental Health Planning, Metropolitan Health Planning Corp., 908 Standard Building, Cleveland, Ohio.

Although dental disease is not usually thought of in terms of life or death, it does impose measureable costs. In 1972, the American population experienced an estimated 20,013,000 days of restricted activities from dental disease. Of these, 7,831,000 days were spent in bed. A total of 3,473,000 days were lost because of dental disease in 1973 among the American labor, totalling 91,040,000 people. That same year, a total of $5,385,000,000 was spent for dental treatment in the United States.

In 1973, 35,100,000 American children were enrolled in kindergarten through eighth grades. It has been estimated that the average daily absentee rate in schools is 10%. Thus, an estimated 351,000 pupils would be absent from school each day. Of these 351,000, six per cent—or 21,060—are estimated to be absent each day because of dental disease. This figure does not include those children who are in school but who are inattentve due to discomfort.

The prevalence of dental disease may be reduced through such measures as prevention and treatment.

Prevention

The bromide, "An ounce of prevention is worth a pound of cure", is especially appropriate for dental disease. Prevention means the use of fluorides, programs in dental health education, and early visits to the dentist.

A classic epidemiological study during this century established fluorides as an effective agent in reducing dental caries, with a great margin of safety in terms of physiological processes.

The most effective method of fluoridation is by ingestion of 1.0 part per million fluoride through central drinking water. This method is effective in two ways. First, fluoridated drinking water leads to a caries reduction rate of 60%, a rate higher than any other fluoridation method. Second, this method is implemented with mechanical ease and at low cost.

Currently, 60% of the American population is receiving such benefits through fluoride in central drinking water supplies. Many reasons are given as to why the total population does not have fluoridated water, including inaccessibilty of a central water supply. An alternative, then, would be to apply fluorides through the schools in such communities. The quantity of fluorides in school fluoridation projects should be greater than one part per million since school is in session only one-third of the day. But, in controlled studies, a significant caries reduction has been realized in these children with no harmful effects.

Where broad-scale ingestion may not be feasible, topical application is an appropriate alternative. These would be offered in addition to any methods used by private dentists. One approach is through the use of weekly fluoride mouth rinses by pupils in classrooms during the school year, such as a program just begun in Geauga County, Ohio. Such methods have significantly reduced dental caries.

Since fluoridation is an effective method to reduce dental caries, and since people in some unfluoridated areas have experienced staggering dental expenditures as noted in public assistance programs, an expedient measure would be to encourage fluoridation by returning treatment costs to states directly proportionate to its degree of fluoridation and other preventive measures.

Denal caries reduction through fluoridation requires no motivation at virtually no expense. Periodontal disease prevention, on the other hand, does require motivation to improve and/or maintain personal dental health habits, and to visit the dentist before neglected areas become problems.

It would be desirable if everyone had access to dentists who would provide dental health education. But, the 60% of the population who visit dentists occasionally are probably there only because of an acute need and are not receptive to preventive measures. The 20% who visits once a year may be partially receptive, but the 20% who visit regularly would be the most receptive. The latter two groups are a minority of the population; therefore, a place is needed where prevention could be taught under more ideal teaching conditions, where reception would be better, and where a broader segment of the population would be reached—in the school system!

Preventive measures taught in the classroom would lead to reduction in both dental caries and periodontal disease. With structured programs in dental health education, incorporated into the total curriculum, pupils will develop personal dental health habits, reduce their fears of the dentist, learn the value of selection of non-cariogenic foods, visualize the need for early and continued visits to the dentist, and will learn to exercise appropriate measures in case of dental accidents and emergencies. The Ohio Program for Dental Health Education in Schools, administered by the Metropolitan Health Planning Corporation of Cleveland, is one such prorgam.

Treatment

As health becomes a right, as financing mechanisms become more available, and as people become more aware of the need to improve their dental health by prevention and treatment, we can expect a greater demand for dental services.

The treatment of dental disease, however, rests with dentists, and they are free to practice where they wish. We have seen that even states that are big producers of dentists experience great dental manpower shortages. So, retention and distribution of dentists is very important.

An issue before government, therefore, is to increase the availability and accessibility of services to those in need. Equitable distribution of dentists among those in need calls for realistic inducements to attract dentists to underserved areas. Such measures might include the encouragement of matching programs between dentists and specific communities, grants and/or tax reductions for practices in dental manpower shortage areas, and extensions of postgraduate training in smaller cities.

Increasing the manpower will provide only a partial response to the demand, however. Another practical measure is expanding the duties of dental auxiliaries. This means that dental auxiliaries should be delegated more responsibility under supervision of a dentist, than has been usually done. Such a precedent has already been set in the medical profession.

Provision of insured dental care to every American who wants it would be ideal. But, costs may preclude such a monumental venture. In that case, I would suggest that care be provided to two categories of people with equal priority—children up to age 15, and senior citizens.

If National Health Insurance will cover only the extremes in age, the remainder of the population should be covered by other third parties such as organized labor.

Children will have less accumulated dental disease than young adults or adults. If they receive incremental care—beginning as they enter school and maintaining it on a yearly basis under controlled conditions—the total costs will be less. An incremental program from the beginning would be more practical than a program to treat children who are victims of accumulated neglect. Since children are required to attend school by law, the best controlled conditions would be to have dental treatment facilities in schools. Experience in other countries has shown, however, that when only treatment was provided in such controlled situations the patient allows his dental health to revert miserably to an undesirable state when treatment stops. One must be motivated to maintain a healthy condition. Therefore, a strong program of dental health education in schools becomes mandatory.

At the other end of the age spectrum we find the senior citizens, whose health may be failing. An adjunct to good health is a nutritious diet. An integral part of the utilization of a nutritious diet is a healthy mouth. This ofttimes forgotten or ignored segment of the population in many instances is forced to have extraction and dentures rather than encouraged to maintain natural teeth. Because this method seems on the surface to solve the problem, the elderly ofttimes become permanent dental cripples for their remaining years. Dental services should be generally available to the elderly, and one place where this could be structured is through the nation's network of certified extended care facilities.

Summary and recommendations

I have brought to your attention that dental disease is virtually universal, that its costs extend deep into our pocketbooks, it robs the education of our children, and it reduces the nation's goods and services. As knowledge and financing increase, we can expect the demand for dental services to increase. Though treatment demands will continue, the magnitude of treatment required would be reduced through universal fluoridation. Since providing treatment services for all who demand it is expensive, and if priorities must be made, children and senior citizens should be considered first.

In an effort to improve the dental health of American citizens through National Health Insurance, I recommend:

(1) encouragement of the utilization of fluorides, both ingested and topically applied, through returns of treatment costs directly proportionate to states' fluoridation;

(2) provision for dental health education and treatment facilities for children in schools;

(3) promotion of the use of expanded duties of dental auxiliaries;

(4) encouragement of dentists to work in manpower shortage areas; and

(5) provision of care for senior citizens generally, and specifically, in extended care facilities.

Mr. COTTER. Thank you, Doctor.

Dr. Slaughter?

STATEMENT OF TERRY W. SLAUGHTER, D.D.S.

Dr. SLAUGHTER. Thank you, Mr. Chairman.

I am Terry W. Slaughter of Salinas, Calif. I am a practicing oral and maxillofacial surgeon and vice president of the American Society of Oral Surgeons. I appear before the subcommittee as a representative of the society. With me is the society's counsel, Edwin S. Cohen, of Covington & Burling, Washington, D.C.

The American Society of Oral Surgeons (ASOS) is the official organization of nearly 3,700 oral surgeons representing all 50 States, the District of Columbia, and Puerto Rico. Today all members must complete 3 or more years in an accredited surgical residency in a hospital following completion of 4 years of dental school. Members limit their practice to oral surgery in offices and in hospitals as staff members.

In the interest of conserving the committee's time, I will summarize my statement. I would like, however, to submit the full statement for the record.

The ASOS is here today to express its concern about four specific problems. These problems and their suggested solutions are potentially applicable to every national health insurance bill.

I. ELIMINATE DISCRIMINATION BETWEEN PHYSICIANS AND ORAL SURGEONS AND OTHER DENTISTS IN THE PROVISION OF COVERED SERVICES

The professional practice of oral surgeons overlaps with that of physicians to a significant extent. Both groups, for example, often admit their patients to hospitals and perform complicated maxillofacial procedures. Further, both groups often provide diagnostic care and treatment of oral infections. Medicare, however, will pay all benefits for these services if they are performed by a physician, but the medicare intermediary will routinely reject the payment request if the diagnostic care or treatment of oral infection was performed by an oral surgeon.

This discrimination should be corrected in present law and should not be included in any national health insurance program.

It may assist your understanding of this problem if I explain how our services are covered under present law. Medicare only covers the services of dentists when they constitute so-called physician's services. It is necessary, therefore, to look at the definition of "physician" in deciding whether a specific service is covered. "Physician" is defined to include a doctor of dental or oral surgery licensed by his State "but only with respect to": (1) Surgery related to the jaw or any contiguous structure, (2) reduction—that is, the alinement—of fractures of the jaw or any facial bone.

As existing law is interpreted by the Social Security Administration, a dentist only functions as a "physician," and his services are only covered when he is involved in the actual performance of surgery or reduction. Thus, the law seriously discriminates against oral surgeons by excluding important nonsurgical functions—such as the management of salivary gland infections—which are covered if performed by a physician. None of these functions involve routine dental care, which is separately excluded under existing law whether performed by an oral surgeon or physician. Absolutely no logical reason exists to support this unfair treatment.

This problem has serious consequences for the patient, and is important to the professional life of the dentist. If the patient is aware of the discrimination, his freedom of choice of provider between a physician and a dentist will be prejudiced. If he is not aware of this legal pitfall, he will be deprived of reimbursement for what surely must appear to him to be a completely arbitrary distinction.

To put this problem into concrete terms, the Social Security Administration's interpretation of present law—

> Denied payment to a patient for the services of an oral surgeon who had been called to the emergency room by the patient's physician to locate a bullet in the patient's tongue;
>
> Forced a 73-year-old woman to find her own means of paying for an oral surgeon's evaluation of oral and maxillofacial injuries suffered in an automobile accident;
>
> Denied reimbursement to an elderly man who was treated by an oral surgeon for temporomandibular—jaw—joint arthritis;
>
> Denied payment for drug injections administered by an oral surgeon to a facial nerve of a patient suffering from tic douloureux, the most painful and debilitating of all facial pains; and
>
> Denied payment to a patient for treatment by his oral surgeon of an obstruction and swelling of a salivary gland.

These are not isolated examples. The files of our society contain numerous similar cases. The problem is serious and it needs prompt correction. The solution will not increase the scope of covered services.

Finally, several of the States have carried this discrimination into their medicaid programs by adopting the medicare definition of "physician." If medicaid is included under national health insurance, it should also be amended to prohibit this inequity.

II. COVER INPATIENT HOSPITAL SERVICE FOR ALL DENTAL PROCEDURES THAT REQUIRE HOSPITALIZATION

National health insurance should provide coverage for inpatient hospital expenses of patients requiring admission for a dental procedure. Existing medicare law differentiates between cases in which the dental procedure itself is a covered service—and thus the dentist's fee is reimbursable—and cases involving noncovered procedures. If the procedure is covered, the inpatient hospital expenses are also covered. However, the present medicare statute as interpreted by the Social Security Administration restricts the payment of inpatient hospital expenses in the case of a noncovered dental procedure to circumstances in which they patient's underlying medical condition, and not solely his dental condition, requires hospitalization. The only example of a medical condition justifying the hospitalization of a patient for a noncovered dental service given in the Social Security Administration's "Intermediary Manual" is "a patient who has a history of repeated heart attacks who must have all of his teeth extracted."

The effect of existing law is to preclude hospitalization coverage where, in the judgment of the patient's dentist, the severity of his dental condition alone requires hospitalization for the safe performance of a noncovered dental procedure. In these cases the patient must find his own means of payment for the hospital expenses. Sample medicare rejections when contrasted with the example in the SSA manual starkly demonstrate the problem under present law. For example—

> An 81-year-old woman in Florida who was hospitalized by her oral surgeon for the removal of six maxillary teeth had her claim rejected because the medicare intermediary found that she was treated for a purely dental condition;
>
> A 93-year-old man in Illinois who was hospitalized by his oral surgeon for the extraction of 11 seriously diseased teeth had his claim denied; and
>
> In Missouri a medicare patient had to pay his own hospital bill because he was hospitalized by his oral surgeon for preparation of the lower jaw for dentures using a skin graft.

These are only three of the examples regularly received by our society every year but they graphically illustrate the problem.

ASOS urges that national health insurance, including any continuation of medicare and medicaid, should cover inpatient hospital expenses if in the judgment of his dentist the severity of a patient's dental condition requires him to be hospitalized for performance of a dental procedure notwithstanding that the procedure itself is not a covered health service. This will not increase the coverage of dental fees. It will only increase hospital coverage and aid the patient. The Social Security Administration in 1973 estimated the additional first-year Federal costs of coverage of medicare patients in such instances to be $4 million.

III. PROVIDE FOR REPRESENTATION OF DENTISTS ON PSRO'S

On September 19, 1975, Dr. I. Lawrence Kerr appeared before this subcommittee on behalf of both the ASOS and the American Dental Association. Dr. Kerr urged you to amend the professional standards review legislation to mandate the participation of dentists in the review of dental services and the inclusion of dentists on both the statewide and national PSR councils.

In the interest of brevity, I will not reiterate our position except to emphasize that oral surgeons accept the responsibility of peer review and seek only the right to review their own services. The society does not believe that it is reasonable to subject dentistry to the highly complicated and exacting PSRO system without having entitlement to representation in its development, operation, and final adjudicatory functions.

IV. EMERGENCY DENTAL CARE

The final matter that I will discuss today is the only one which involves an extension of dental coverage. The ASOS believes that any national health insurance bill that this subcommittee reports out should provide emergency dental care.

Based upon a recent study by the American Society of Oral Surgeons, the average community hospital of 250 or more beds treats 25,000 to 40,000 patients annually in its emergency department. Of this number it is estimated that 2 to 4 percent is for emergency dental care, including treatment of conditions relating to the mouth and associated structures. These patients often suffer from severe and disabling pain.

The definition of emergency dental care that the society has prepared for your review covers only those severe conditions which, if not promptly treated, will result in death or substantial functional impairment of important oral structures. For example, traumatic injuries to the jaws and teeth and their supporting structures, or tooth infections spreading into the airway, are often life-threatening. Further, hemorrhage and airway impairment may have dire consequences for the patient. Immediate and palliative treatment of these conditions is as essential to health as any other service that may be provided by national health insurance.

The society has submitted to your staff example of the first two points covered in my statement. We are prepared to submit examples of the type of cases that would be included under our definition of emergency dental care. To assist you in dealing with these problem areas I have attached suggested statutory language to my full statement.

I appreciate this opportunity to appear before the subcommittee today.

Thank you.

[The prepared statement and attachment follow:]

STATEMENT OF DR. TERRY W. SLAUGHTER, THE AMERICAN SOCIETY OF ORAL SURGEONS

Mr. Chairman and members of the subcommittee: I am Terry W. Slaughter of Salinas, California. I am a practicing oral and maxillofacial surgeon and Vice-President of the American Society of Oral Surgeons. I appear before the Subcommittee as a representative of the Society. With me is the Society's counsel, Edwin S. Cohen, of Covington & Burling, Washington, D.C.

The American Society of Oral Surgeons ("ASOS") is the official organization of nearly 3,700 oral surgeons representing all fifty states, the District of Columbia and Puerto Rico. Today all members must complete three or more years in an accredited surgical residency in a hospital following completion of four years of dental school. Members limit their practice to oral surgery in offices and in hospitals as staff members.

The ASOS is here today is express its concern about four specific problems. These problems and their suggested solutions are potentially applicable to every national health insurance bill.

The first three problem areas that I would like to address exist in the present Medicare program and will, unless resolved, be exacerbated by national health insurance. With respect to these three matters, we seek to correct existing discrimination against oral surgeons and other dentists and their patients. We emphasize that the solutions we propose for these three problems would not increase the scope of covered dental services. Moreover, only the solution to the second problem will even modestly increase the scope of federally financed hospital care.

These three problem areas can be summarized as:

(1) to eliminate the discrimination against oral surgeons and other dentists and their patients in the payment for services provided by both physicians and dentists;

(2) to cover the inpatient hospital expenses for all of those patients whose hospitalization is required for the performance of dental procedures; and

(3) to provide for the representation of dentists on PSROs.

We have compiled a binder of documentary examples of cases where the serious inequities addressed in my first two points are demonstrated. A copy of this binder has been delivered to the Subcommittee staff, at its request, and is available for your review.

The fourth and final matter that we are concerned with does involve an expansion of covered dental benefits. The Society believes that national health insurance should cover emergency dental care.

I would like to submit, along with my statement, suggested statutory language that would correct the first two problems addressed. I would also like to submit the ASOS definition of emergency dental care. Further, we are prepared to assist the staff in drafting statutory language to deal with any of these matters.

I. ELIMINATE DISCRIMINATION BETWEEN PHYSICIANS AND ORAL SURGEONS AND OTHER DENTISTS IN THE PROVISION OF COVERED SERVICES

The professional practice of oral surgeons overlaps with that of physicians to a significant extent. Both groups, for example, often admit their patients to hospitals and perform complicated maxillofacial procedures. Further, both groups often provide diagnostic care and treatment of oral infections. Medicare, however, will pay all benefits for these services if they are performed by a physician, but the Medicare Intermediary will routinely reject the payment request if the diagnostic care or treatment of oral infection was performed by an oral surgeon.

This discrimination should be corrected in present law and should not be included in any national health insurance program.

It may assist your understanding of this problem if I explain how our services are covered under present law. Medicare only covers the services of dentists when they constitute so-called "physician's services." It is necessary, therefore, to look at the definition of "physician" in deciding whether a specific service is covered. "Physician" is defined to include a doctor of dental or oral surgery licensed by his state "but only with respect to" (1) surgery related to the jaw or any contiguous structure or (2) reduction (that is, the alignment) of fractures of the jaw or any facial bone.

As existing law is interpreted by the Social Security Administration, a dentist only functions as a "physician," and his services are only covered, when he is involved in the actual performance of surgery or reduction. Thus the law seriously discriminates against oral surgeons by excluding important nonsurgical functions (such as the management of salivary gland infections) which are covered if performed by a physician. None of these functions involves routine dental care, which is separately excluded under existing law whether performed by an oral surgeon or physician.

Absolutely no logical reason exists to support this unfair treatment. Both disciplines are professionally trained and licensed by state law to perform these procedures. If this inequity is continued in national health insurance, qualified dentists will be excluded from performing many of the important procedures of their profession for an even larger segment of the population.

This problem has serious consequences for the patient, and is important to the professional life of the dentist. If the patient is aware of the discrimination, his freedom of choice of provider between a physician and a dentist will be prejudiced. If he is not aware of this legal pitfall, he will be deprived of reimbursement for what surely must appear to him to be completely arbitrary distinction.

To put this problem into concrete terms, the Social Security Administration's interpretation of present law:

Denied payment to a patient for the services of an oral surgeon who had been called to the emergency room by the patient's physician to locate a bullet in the patient's tongue;

Forced a 73 year old woman to find her own means of paying for an oral surgeon's evaluation of oral and maxillofacial injuries suffered in an automobile accident;

Denied reimbursement to an elderly man who was treated by an oral surgeon for temporomandibular (jaw) joint arthritis;

Denied payment for drug injections administered by an oral surgeon to a facial nerve of a patient suffering from tic douloureux, the most painful and debilitating of all facial pains; and

Denied payment to a patient for treatment by his oral surgeon of an obstruction and swelling of a salivary gland.

These are not isolated examples. The files of our Society contain numerous similar cases. The problem is serious and it needs prompt correction. The solution will not increase the scope of covered services. The existing exclusion of coverage of routine dental care found in § 1862(a)(12) would not be changed. Those services that fall into this category would still not be covered. The solution of this problem will merely assure that patients will not be denied reimbursement for otherwise covered services solely because of the academic degree of the provider.

To perpetuate this inequity in national health insurance would compound the unfairness to both the patient and the oral surgeon.

Some national health insurance bills have tried to deal with this problem. The Society wholeheartedly supports this effort. The authors of H.R. 21, for example, attempted affirmatively to put dentists on a parity with physicians. In § 42(b) the bill covers the services of dentists "when performing oral surgery or other procedures." This choice of words, however, may well leave the door open for the Social Security Administrator to decide that "other procedures" modifies "oral surgery." Such an interpretation, though perhaps a possible construction, would negate congressional will and preserve the present inequity. The attempt in H.R. 21 to treat physicians and oral surgeons equally underscores the need for the Subcommittee to adopt only the most straightforward corrective statutory language in dealing with this problem area. We, therefore, urge that the amendment in the attachment to my statement be considered. We also are prepared to meet with the staff to help develop other corrective language.

Finally, several of the states have carried this discrimination into their Medicaid programs by adopting the Medicare definition of "physician." If Medicaid is included under national health insurance it should also be amended to prohibit this inequity. The attachment to my statement also contains language that would accomplish this end.

II. COVER INPATIENT HOSPITAL SERVICE FOR ALL DENTAL PROCEDURES THAT REQUIRE HOSPITALIZATION

National health insurance should provide coverage for inpatient hospital expenses of patients requiring admission for a dental procedure. Existing Medicare law differentiates between cases in which the dental procedure itself is a covered service (and thus the dentist's fee is reimbursable) and cases involving noncovered procedures. If the procedure is covered, the inpatient hospital expenses are also covered. However, the present Medicare statute as interpreted by the Social Security Administration restricts the payment of inpatient hospital expenses in the case of a noncovered dental procedure to circumstances in which the patient's underlying medical condition, and not solely his dental condition, requires hospitalization. The only example of a medical condition justifying the hospitalization of a patient for a noncovered dental service given in the Social Security Administration's "Intermediary Manual" is "a patient who has a history of repeated heart attacks who must have all of his teeth extracted."

The effect of existing law is to preclude hospitalization coverage where, in the judgment of the patient's dentist, the severity of his dental condition alone requires hospitalization for the safe performance of a noncovered dental procedure. In these cases the patient must find his own means of payment for the hospital expenses. Sample Medicare rejections when contrasted with the example in the S.S.A. manual starkly demonstrate the problem under present law. For example:

An 81-year-old woman in Florida who was hospitalized by her oral surgeon for the removal of six maxillary teeth had her claim rejected because the Medicare Intermediary found that she was treated for a purely dental condition;

A 93-year-old man in Illinois who was hospitalized by his oral surgeon for the extraction of eleven seriously diseased teeth had his claim denied; and

In Missouri a Medicare patient had to pay his own hospital bill because he was hospitalized by his oral surgeon for preparation of the lower jaw for dentures using a skin graft.

These are only three of the examples regularly received by our Society every year, but they graphically illustrate the problem.

ASOS urges that national health insurance, including any continuation of Medicare and Medicaid, should cover inpatient hospital expenses if in the judgment of his dentist the severity of a patient's dental condition requires him to be hospitalized for performance of a dental procedure notwithstanding that the procedure itself is not a covered health service. This will not increase the coverage of dental fees. It will only increase hospital coverage and aid the patient. The Social Security Administration in 1973 estimated the additional first-year federal costs of coverage of Medicare patients in such instances to be four million dollars.

III. PROVIDE FOR REPRESENTATION OF DENTISTS ON PSROS

On September 19, 1975, Dr. I. Lawrence Kerr appeared before this Subcommittee on behalf of both the ASOS and the American Dental Association. Dr. Kerr urged you to amend the Professional Standards Review legislation to mandate the participation of dentists in the review of dental services and the inclusion of dentists on both the statewide and national PSR Councils.

In the interest of brevity, I will not reiterate our position except to emphasize that oral surgeons accept the responsibility of peer review and seek only the right to review their own services. A large number of dentists are presently providing millions of dollars in dental services covered under Titles V, XVIII, and XIX. Since many of the national health insurance bills being considered would expand the existing coverage for dental services and, therefore, the review of dental services by PSROs, Dr. Kerr's remarks are even more urgent in the present context. The Society does not believe that it is reasonable to subject dentistry to the highly complicated and exacting PSRO system without having entitlement to representation in its development, operation, and final adjudicatory functions.

IV. EMERGENCY DENTAL CARE

The final matter that I will discuss today is the only one which involves an extension of dental coverage. The ASOS believes that any national health insurance bill that this Subcommittee reports out should provide emergency dental care.

Based upon a recent study by the American Society of Oral Surgeons, the average community hospital of 250 or more beds treats 25,000 to 40,000 patients annually in its emergency department. Of this number, it is estimated that two to four percent is for emergency dental care, including treatment of conditions relating to the mouth and associated structures. These patients often suffer from severe and disabling pain.

Some national health insurance bills presently being considered by the Subcommittee have included provisions for emergency dental care. This is true of H.R. 363 and H.R. 6222. The crucial definition in these bills, however, differs from the Society's suggested definition that we are attaching to this statement. Other bills being considered, such as H.R. 1 and H.R. 94, include broad dental coverage which will ultimately provide for emergency dental care. The Society recognizes the difficulty in fashioning an adequate definition of emergency dental care but believes that any bill that you report out should explicitly provide for this important care.

The definition of emergency dental care that the Society has prepared for your review covers only those severe conditions which, if not promptly treated, will result in death or substantial functional impairment of important oral structures. For example, traumatic injuries to the jaws and teeth and their supporting structures, or tooth infections spreading into the airway, are often life-threatening. Further, hemorrhage and airway impairment may have dire consequences for the patient. Immediate and palliative treatment of these conditions is as essential to health as any other service that may be provided by national health insurance.

I appreciate this opportunity to appear before the Subcommittee today.

Thank you.

Attachment

American Society of Oral Surgeons Suggested Statutory Language

A. ELIMINATE DISCRIMINATION BETWEEN M.D. AND ORAL SURGEON IN THE PROVISION OF COVERED SERVICES

Medicare (*Title XVIII*)

In the framework of the existing Medicare statute and those national health insurance bills which continue it (e.g. H.R. 1) parity between the M.D. and oral surgeon can be achieved by amending Section 1861(r) (2) to read as follows:

"(2) a doctor of [dentistry or of] dental [or oral] surgery *or of dental medicine* who is legally authorized to practice dentistry by the State in which he performs such function *and who is acting within the scope of his license when he performs such function* [but only with respect to (A) surgery related to the jaw or any structure contiguous to the jaw or (B) the reduction of any fracture of the jaw or any facial bone, or (C) the certification required by section 1814 (a) (2) (E) of this Act]," [1]

The existing exclusion from coverage of routine dental care under Section 1862(a) (12) ("services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth") would continue to apply in order to assure that the inclusion of dentists within the definition of "physician" would not increase the scope of covered services but would function only to allow oral surgeons as well as doctors of medicine to perform covered services.

In those national health insurance proposals that do not include the specific exclusion of routine dental care as in existing law (e.g. H.R. 1 after comprehensive health care benefits become mandated, and H.R. 21.) such an exclusion could be added to the definition of "physician" as an exception to the functions with respect to which a dentist is a "physician." This would prevent any untintended increase in the scope of covered services as a result of the expanded definition of "physician."

Alternatively, the definition of "physician" could be drafted to state affirmatively the functions performed by both doctors of medicine and oral surgeons. (In H.R. 1, for example, such a definition could be given in Section 128(f) (1).)

"A doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he performs such function but only with respect to the diagnosis, the surgical and/or the adjunctive treatment of the diseases, injuries, and defects of the oral and maxillofacial region."

Medicaid (*Title XIX*)

Section 1902 could be amended to add a new subsection (a) (36) as follows:

"Provide that wherever the terms 'physican' and/or 'doctor' are used these terms shall include within their meaning doctors of dental surgery or of dental medicine when they are performing care, services, procedures or benefits covered by the State plan which doctors of dental surgery or of dental medicine are licensed by the State to perform."

B. COVER INPATIENT HOSPITAL SERVICES FOR ALL NONCOVERED DENTAL PROCEDURES THAT REQUIRE HOSPITALIZATION

Hospitalization for noncovered dental procedures could be provided within the framework of those national health insurance bills that continue Medicare by amending § 1814(a) (2) (E) of Title XVIII to read as follows:

"In the case of inpatient hospital services in connection with [the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth] *a dental procedure*, the individual, because of his underlying medical condition and clinical status, *or because of the severity of his dental condition*, requires hospitalization in connection with the provision of such dental services;"

Section 1862(a) (12) of Title XVIII could also be amended to read as follows:

"Where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth, except that payment may be made under Part A in the case of inpatient hospital services in connection with the provision of such *any* dental services if the individual because of his underlying medical condition and clinical status, *or because of the severity of his dental condition,* requires hospitalization in connection with the provision of such services; or"

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[1] The changes in the first two lines of this definition are merely to accord with the appropriate professional nomenclature.

In H.R. 21 this additional hospitalization coverage could be accomplished by amending Section 24 of that bill by adding "or dental" after medical wherever it appears. A similar amendment could be made in H.R. 1 Section 123 (a)(1).

C. INCLUDE EMERGENCY DENTAL CARE AS A COVERED SERVICE

The following definition could be included in the national health insurance bill:

Emergency dental care is the management or treatment of hemorrhage, upper airway impairment, trauma, actute infection, or acute inflammation involving the oral and maxillofacial structures, including the teeth and dentoalveolar processes, which threatens the person's life or substantially impairs the functioning of such structures.

The following explanation of the definition could also be used by the Subcommittee:

I. Treatment of oral and maxillofacial hemorrhage resulting from: A. Trauma; B. Surgery; C. Defects in the bleeding and clotting mechanisms, and D. Tumor.

II. Treatment of upper airway impairment resulting from: A. Trauma; B. Solid or fluid objects foreign to the airway; and C. Infection and inflammation.

III. Treatment of the oral and maxillofacial structures as a result of trauma consisting of: A. Fractures and displacement of teeth and dentoalveolar processes; B. Fractures of jaws and other facial bones; C. Temporomandibular joint injuries; D. Soft tissue injuries.

IV. Treatment of acute infection and inflammation of the oral and maxillofacial structures including the teeth and dentoalveolar processes.

V. Emergency dental care includes examinations, diagnostic and anesthetic services.

Mr. Rostenkowski [presiding]. Thank you, Dr. Slaughter.

Dr. Friedman?

STATEMENT OF JAY W. FRIEDMAN, D.D.S.

Dr. Friedman. Mr. Chairman and members of the committee, my name is Jay Friedman. I am presently dental director of the quality assurance program of U.S. Administrators, based in Los Angeles. I am also a clinical professor in the Department of Community Dentistry at the School of Dentistry, University of Southern California. I am also a clinical professor in the Department of Community Dentistry at the School of Dentistry, University of Southern California. I am a consultant to the Health and Welfare Agency of the State of California and to other governmental and private organization.

My background includes over 20 years of full- and part-time group dental practice serving self-paying patients, patients with third-party indemnity insurance, and unions contracting on a capitation basis. My academic studies include research in hospital medical staff organization—including coauthorship with Milton I. Roemer of "Doctors in Hospitals," 1974—quality evaluation of dental care, and different delivery systems such as HMO-type capitation programs and a New Zealand School Dental Nurse Service.

The reason for giving the background is to, I suppose, imply that I have a very broad background in dental treatment and administration.

I have an abbreviated version of my statement.

Although I bear responsibility for this presentation, much of it represents the judgment and recommendations of many private and public health dentists including some members of the subcommittee's advisory panel, who met in Chicago a few weeks ago. Though each of us might place greater emphasis on one or another recommendation, there was general consensus on the broad principles. These principles and recommendations will be discussed under the following headings: (1) "The Pluralistic Dental Delivery System." (2) "Inclusion of Dentistry in National Health Insurance." (3) "Alternate Delivery Systems and Dental Auxiliaries." (4) "A School-Based Dental Program for Children." (5) "Effect on Adult Care." (6) "Maintaining Title 19 Dental Benefit Programs."

1. THE PLURALISTIC DENTAL DELIVERY SYSTEM

We refer to our Nation as a pluralistic society because it embodies a combination of individualism and group activity, of private and public responsibility and organization, of small entrepreneurial businesses and professions and large corporate and governmental structures. Dentistry is a microcosm of this pluralism.

The predominant delivery system consists of private, solo practitioners serving private, self-paying patients. Unfortunately, it is estimated that less than 20 percent of the population receives comprehensive dental care under this system, and perhaps another 30 percent utilizes it one or more times a year. Almost half the children in the United States under age 15 and 75 percent of children from low-income families have never been to a dentist.

We believe, Mr. Chairman, that the coexistence of multiple delivery systems enhances flexibility, accessibility, and healthy competition. But there are major deficiencies that cannot be solved merely by pumping more money into these systems through national health insurance. Large portions of the population—especially children—do not have access to dental care, as evidenced by the figures previously cited.

2. INCLUSION OF DENTISTRY IN NATIONAL HEALTH INSURANCE

Ideally all necessary and essential dental care should be covered by national health insurance. Even though some of us believe total coverage for the entire population is economically feasible with proper administrative, cost, and quality controls, we recognize that it is not yet politically attractive. Given supplemental private dental insurance that is rapidly developing, total population coverage under NHI may not be necessary. What is necessary is a supplemental delivery system for children.

Estimates of costs for medical care alone in the face of mounting inflation has led to consideration of postponement of any dental care in the first enactment. Such a exclusion would be a grievous error. Rather than a few years' delay, a decade or more might pass before coverage was extended to children. Unless dental care is included at the initiation of national health insurance, available funds are almost certain to be consumed by programs for medical and hospital services.

At the root of this problem is the assignment of values. If dental care for children is assigned such a low value by Congress that it is excluded from first enactment of national health insurance, it will be a total disregard of the recommendations of every responsible public health authority.

Granted that priorities must be established in the world of fiscal reality, they must also be established on the basis of human need. Some consideration has been given to first coverage for emergency dental care or, as you have heard here today, extended to emergency coverage.

Supporting arguments are based on an extension of the primary importance of emergency medical services in life-threatening situations. But few dental emergencies are life-threatening and those that are such as traumatic injuries are usually covered under the medical program, whether the service is provided by a physician, an oral surgeon, or a general dentist.

Most dental emergencies consist of toothaches and related infections for which remedial care can be obtained whether or not the patient has insurance. The cost is not remotely catastrophic and preservation of life rarely requires immediate emergency care. In fact, this type of dental treatment is so accessible that our population is literally experiencing an epidemic of extractions so that 1 out of 5 Americans wears a full upper denture by age 35 and half the population has lost all its teeth by age 75.

Related to emergency dental service is the inclusion of payment for dentures. Although a person without teeth should have prosthetic replacement, first coverage of dentures under national health insurance would not only encourage loss of teeth, it might also deplete the entire funds available for preventive care.

Prevention is composed of two parts. Primary prevention is the prevention of the onset of a disease and in dentistry consists of water fluoridation, health education, topical fluoride applications, "pit and fissure" sealants, plaque control, and diet control. Water fluoridation is the most effective because it does not require individual effort. It should be implemented on a national scale.

The other methods of primary prevention are still in the developmental stage and require individual and/or professional assistance and application. Secondary prevention is remedial in nature, requiring treatment of a disease once it has begun to prevent further sickness and injury to the individual.

Secondary prevention for children consists mainly of early detection of dental decay, its removal, and the preservation of teeth with fillings. Thus, any children's dental program that is based on prevention must provide treatment of existing decay as well as those modalities directed toward preventing the onset of the disease process.

It is this type of coverage that we believe should be included in the first enactment of national health insurance.

3. ALTERNATE DELIVERY SYSTEMS AND DENTAL AUXILIARIES

At the outset of this presentation I described briefly the elements of our pluralistic dental care delivery system. The system best serves ambulatory patients. By increasing financial and manpower support as well as increasing the productive efficiency of the various components, a good part of the ambulatory population can obtain care. But if only 20 percent of the total population is receiving adequate care, it is obvious that a signicant increase in utilization will absorb if not overwhelm ambulatory facilities no matter how much increased efficiency is achieved.

Furthermore, the distribution of dentists does not match the needs of the population within either the major cities where most dentists are located or in outlying areas. For example, there are 229 counties in this Nation, with a population of over 1 million people, which have no dentist at all.

Last year before the House of Representatives Committee on Ways and Means, Dr. James W. Dunning and I remarked:

> Even if private dental practitioners increase their productivity by using expanded duty dental assistants, the question remains how the children can be transported to the dentist. The answer is they generally cannot.
>
> From the viewpoint of obtaining health care services, children must be considered nonambulatory; that is, they must be taken to the dentist by adults. The enormity of the task of transporting 44 million children under age 13 to private dental offices is a logistic nightmare.
>
> But also consider that it would take almost the same number of adults to accompany them. That involves over 40 percent of the total population of the United States just keeping one dental appointment.
>
> * * * If the majority of our children are to receive dental care, the services must be provided, in large part, in school-based programs.

This same recommendation was made in 1972 by the Advisory Committee on Dental Health to the Department of Health, Education, and Welfare. Though largely innovative for the United States, school-based dental care programs have existed for decades in a number of countries with notable success, especially in Norway and New Zealand. The Norwegian system utilizes dentists in the schools whereas the New Zealand School Dental Service is staffed by dental nurses with 2 years' training, after high school, who are supervised by public health dentists. Both countries have virtually eliminated tooth loss in elementary school children by timely examination and filling of teeth.

Most countries that have decided to provide dental care for children in recent years have adopted the New Zealand model with appropriate modifications. Although demonstration projects in the United States have affirmed the feasibility of training this type of paraprofessional, organized dentistry has prevented further experimentation and development.

Although I and many of my colleagues advocate adoption of the New Zealand school dental nurse system, we are more concerned that a school-based program be established regardless of the professional staffing pattern. But it is not inappropriate to point out that there are 85,000 elementary schools in the United States and approximately the same number of practicing dentists. Staffing a school-based program primarily with dentists might well deprive the ambulatory adult population of needed care.

To me it is too much like "robbing Peter to pay Paul." Nonetheless, well-trained dentists utilizing a number of expanded duty dental assistants may very well provide the necessary school services in those areas with a heavy concentration of dentists. If we truly support the concept of pluralism, then we should be willing to develop a number of models not only to provide services, but also to allow comparisons of costs and effectiveness for future guidance.

I submit, Mr. Chairman, that the dental profession which claims to have sufficient capability, be given the opportunity to prove its case. But if this capability is found wanting, then the profession should not be allowed to stand in the way of developing not only an alternate delivery system, but also alternate paraprofessional personnel.

This principle should be part of the mandate for including children's dental care in national health insurance.

4. A SCHOOL-BASED DENTAL PROGRAM FOR CHILDREN

Accessibility—both financial and physical—is the key to the success of any health care program. By placing facilities and personnel directly in schools, the entire school population can be reached. Considering the magnitude of the task, it will be necessary to phase in the children incrementally for direct care such as filling of decayed teeth. However, primary preventive care can be provided the entire school population at the outset of the program.

Certain types of preventive services do not require the services of dentists or school dental nurses—therapists. For example, special auxiliaries trained in a few weeks' time can teach toothbrushing, flossing of the teeth, and good diet. They can also supervise the administration of flouride mouth rinses by students themselves. These rinses or gels can be dispensed to entire classrooms of children at frequent intervals to maximize the prevention of cavities. Pit and fissure sealants can be applied to individual students by these auxiliaries under the supervision of dentists, dental hygienists, and school dental nurses. Student leaders can participate in these educational and treatment procedures, encouraging participation among their peers.

Since it would be impossible to provide fillings for all children at once, priorities must be established. At the outset we recommend the program begin with two age groups—6 to 7 year olds and 10 to 11 year olds. Suffice it to say that we believe such an approach maximizes long-term results because it is at these ages that the permanent molars can be best protected. In subsequent years the other age groups would be added incrementally until the entire school population is included.

Let me emphasize again, Mr. Chairman, that this recommendation is for prevention—primary and secondary prevention. Unless prevention is practiced on a continuous basis throughout the life of the individual, much effort and money will have been wasted. This has been the experience of many well-intentioned programs such as Headstart which offer the children neither followup nor continuity. It has been the experience of programs that offer only primary prevention—health education and topical flourides—but which fail to carry through with secondary preventive procedures such as fillings to prevent tooth loss.

Only basic dental care need be provided in the school clinics. Children with special dental problems will be referred to private dentists. Thus, the private sector will supplement the school program. This point is extremely important because the success of a school-based program is linked to the acceptability, cooperation, and participation of private dental practitioners.

What would be the cost of such a program? In Saskatchewan where a school-based program utilizing New Zealand-type dental nurses has completed its first year of operation, costs are estimated at about $35 per child.

In our proposal for a similar pilot project a few years back Dr. John I. Ingle—former dean of the University of Southern California School of Dentistry and now with the National Academy of Sciences

Institute of Medicine—and I came up with a similar estimate, amortizing startup costs of training and equipping in the clinics over a 10-year period. At current dental fees a single visit to a private dentist would cost that much just for examination, cleaning, and X-rays. With four or five fillings, the cost could easily exceed $100. Thus, a school-based program would save up to 65 percent of the cost for the same services provided by private dentists.

I believe this same estimate of costs should be applied whether dental nurses or dentists are the primary providers in the school clinics. Where dentists are employed along with multiple expanded function dental assistants, their productivity has been increased by as much as 400 percent. As important as cost savings are, even more important would be the provision, for the first time in the history of our Nation, of needed dental care for the majority of our children.

5. EFFECT ON ADULT DENTAL CARE

Parents would be relieved of the enormous burden of out-of-pocket expenditures once the program was in full swing. More money would thus be available for their own dental care. Far from incurring loss of income, dentists have everything to gain from supporting a school-based program.

A later effect would be the enlargement of the older population that would continue to receive periodic dental care, as children become adults. Studies of the New Zealand population have demonstrated a continually increasing utilization of private dentists and a corresponding decrease in tooth loss and the number of denture wearers.

Furthermore, overall expenditures are reduced when maintenance care is provided on a continual basis. The amount of time required to maintain patients in good health is perhaps a third or less than the time required to repair the ravages of neglect.

When we speak of a school-based program for children, we are also addressing the long-term dental health care needs of the adult population as well.

6. MAINTAINING TITLE 19 DENTAL BENEFIT PROGRAMS

In the least, present levels of care provided recipients of State aid programs should be maintained. Those States which presently provide little or no benefits should be required to meet acceptable levels of care if they are to receive national health insurance support for a school-based children's program. Since a large portion of title 19 dental funds are expended for children's care, relief from this burden should allow increased dental benefits for the adult population.

CONCLUSIONS

(1) The existing dental care delivery system in the United States is inadequate to meet the entire needs of the population. (2) A school-based preventive dental care program is a practical means of assuring that children receive essential care. (3) For dental care to be provided efficiently, effectively, and economically under national health insurance, unrestricted development and utilization of auxiliary or paradental personnel must be encouraged if not mandated in supervised

environments such as school clinics. (4) The time has long since passed when further delays can be justified. Dental care for children must be included in the first enactment of national health insurance.

Thank you, Mr. Chairman and members of the committee, for the opportunity to make this presentation.

[The prepared statement follows and addendum:]

STATEMENT OF JAY W. FRIEDMAN, D.D.S., M.P.H., DENTAL DIRECTOR, U.S. ADMINISTRATORS

Mr. Chairman, members of the committee, my name is Dr. Jay W. Friedman. I am presently Dental Director of the Quality Assurance Program of U.S. Administrators, based in Los Angeles. I am also a Clinical Professor in the Department of Community Dentistry at the School of Dentistry, University of Southern California. I am a consultant to the Health and Welfare Agency of the State of California and to other governmental and private organizations. My background includes over 20 years of full and part-time group dental practice serving self-paying patients, patients with third party indemnity insurance, and unions contracting on a capitation basis. My academic studies include research in hospital medical staff organization (including co-authorship wtih Milton I. Roemer of Doctors in Hospitals, 1974), quality evaluation of dental care, and different delivery systems such as HMO-type capitation programs and the New Zealand School Dental Nurse Service. Although I bear responsibility for this presentation, much of it represents the judgment and recommendations of many private and public health dentists including some members of the Subcommittee's Advisory Panel, who met in Chicago a few weeks ago. Though each of us might place greater emphasis on one or another recommendation, there was general consensus on the broad principles. These principles and recommendations will be discussed under the following headings:

1. The Pluralistic Dental Delivery System.
2. Inclusion of Dentistry in National Health Insurance.
3. Alternate Delivery Systems and Dental Auxiliaries.
4. A School-Based Dental Program for Children.
5. Effect on Adult Care.
6. Maintaining Title 19 Dental Benefit Programs.

1. THE PLURALISTIC DENTAL DELIVERY SYSTEM

We refer to our nation as a pluralistic society because it embodies a combination of individualism and group activity, of private and public responsibility and organization, of small entreprenurial businesses and professions and large corporate and governmental structures. Dentistry is a microcosm of this pluralism.

The predominant delivery system consists of private, solo practitioners serving private, self-paying patients. Unfortunately, it is estimated that less than 20 percent of the population receives comprehensive dental care under this system, and perhaps another 30 percent utilizes it one or more times a year. Almost half the children in the United States under age 15 and 75 percent of children from low-income families have never been to a dentist.

Various state and federal agencies also provide dental care to specific populations in governmentally owned or sponsored facilities. These include the Public Health Service, the Indian Health Service, the Coast Guard, the Army, Navy and Air Force, the Veterans Administration, Neighborhood Health Centers Health Maintenance Organizations, state and county prison systems. There are also a number of public care programs administered by local schools, county and city health departments. In most of these programs, dentists and dental hygienists are salaried employees, with funding derived from local, state and federal taxes.

A third system, small in size but growing in influence and numbers, consists of group dental practices organized to serve specific populations on a prepaid capitation basis. Stimulated by the models of the more successful prepaid medical programs, these group practices combine the incentives of independent private, solo practice with the advantages of organized financing and the efficiencies of shared capital and administrative costs. They represent a compromise between what is sometimes called the nonsystem of private practice and what is ofttimes the too rigid and inefficient governmentally run system. It is the model that Congress intended to promote in the original Health Maintenance Organization (HMO) legislation.

We believe, Mr. Chairman, that the co-existence of multiple delivery systems enhances flexibility, accessibility, and healthy competition. But there are major deficiencies that cannot be solved merely by pumping more money into these systems through national health insurance. Large portions of the population—especially children—do not have access to dental care, as evidenced by the figures previously cited.

2. INCLUSION OF DENTISTRY IN NATIONAL HEALTH INSURANCE

Ideally, all necessary and essential dental care should be covered by National Health Insurance (NHI). Even though some of us believe total coverage for the entire population is economically feasible with proper administrative, cost and quality controls, we recognize that it is not yet politically attractive. Given supplemental private dental insurance that is rapidly developing, total population coverage under NHI may not be necessary. What is necessary is a supplemental delivery system for children.

Estimates of costs for medical care alone in the face of mounting inflation has led to consideration of postponement of any dental care in the first enactment. Such an exclusion would be a grievous error. Rather than a few years delay, a decade or more might pass before coverage was extended to children. Unless dental care is included at the initiation of National Health Insurance, available funds are almost certain to be consumed by programs for medical and hospital services.

At the root of this problem is the assignment of values. If dental care for children is assigned such a low value by Congress that it is excluded from first enactment of National Health Insurance, it will be at total disregard of the recommendations of every responsible public health authority.

Granted that priorities must be established in the world of fiscal reality, they must also be established on the basis of human need. Some consideration has been given to first coverage for emergency dental care. Supporting arguments are based on an extension of the primary importance of emergency medical services in life-threatening situations. But few dental emergencies are life-threatening and those that are such as traumatic injuries are usually covered under the medical program, whether the service is provided by a physician, an oral surgeon, or a general dentist. Most dental emergencies consist of toothaches and related infections for which remedial care can be obtained whether or not a patient has insurance. The cost is not remotely "catastrophic" and preservation of life rarely requires immediate emergency care. In fact, this type of dental treatment is so accessible that our population is literally experiencing an epidemic of extractions so that one out of five Americans wears a full upper denture by age 35 and half the population has lost all its teeth by age 75.

Related to emergency dental service is the inclusion of payment for dentures. Although a person without teeth should have prosthetic replacement, first coverage of dentures under National Health Insurance would not only encourage loss of teeth, it might also deplete the entire funds available for preventive care.

Neither emergency dental care nor prosthetic replacement of the natural teeth is consistent with emphasis on prevention that is fundamental to the success of National Health Insurance. Since total coverage for all dental care is not possible at this time, or in the near future, prevention rather than extraction and dentures must be given first priority.

Prevention is composed of two parts. Primary prevention is the prevention of the onset of a disease and in dentistry consists of water fluoridation, health education, topical fluoride applications, "pit and fissure" sealants, plaque control and diet control. Water fluoridation is the most effective because it does not require individual effort. It should be implemented on a national scale. The other methods of primary prevention are still in the developmental stage and require individual and/or professional assistance and application. Secondary prevention is remedial in nature, requiring treatment of a disease once it has begun to prevent further sickness and injury to the individual. Secondary prevention for children consists mainly of early detection of dental decay, its removal and the preservation of teeth with fillings. Thus, any children's dental program that is based on prevention must provide treatment of existing decay as well as those modalities directed towards preventing the onset of the disease process.

It is this type of coverage that we believe should be included in the first enactment of National Health Insurance.

3. ALTERNATIVE DELIVERY SYSTEMS AND DENTAL AUXILIARIES

At the outset of this presentation, I described briefly the elements of our pluralistic dental care system. The system best serves ambulatory patients. By increasing financial and manpower support as well as increasing the productive efficiency of the various components, a good part of the ambulatory population can obtain care. But if only 20 percent of the total population is receiving adequate care, it is obvious that a significant increase in utilization will absorb if not overwhelm ambulatory facilities no matter how much increased efficiency is achieved. Furthermore, the distribution of dentists does not match the needs of the population within either the major cities where most dentists are located or in outlying areas. For example, there are 229 counties in this Nation, with a population of over one million people, which have no dentist at all.

Last year before the House of Representatives Committee on Ways and Means, Dr. James W. Dunning and I remarked:

"Even if private dental practitioners increase their productivity by using expanded duty dental assistants, the question remains how the children can be transported to the dentist. The answer is they generally cannot.

"From the viewpoint of obtaining health care services, children must be considered nonambulatory; that is, they must be taken to the dentist by adults. The enormity of the task of transporting 44 million children under age 13 to private dental offices is a logistic nightmare.

"But also consider that it would take almost the same number of adults to accompany them. That involves over 40 percent of the total population of the United States just keeping one dental appointment.

"* * * If the majority of our children are to receive dental care, the services must be provided, in large part, in school-based programs."

This same recommendation was made in 1972 by the Advisory Committee on Dental Health to the Department of Health, Education, and Welfare. Though largely innovative for the United States, school-based dental care programs have existed for decades in a number of countries with notable success, especially in Norway and New Zealand. The Norwegian system utilizes dentists in schools whereas the New Zealand School Dental Service is staffed by dental nurses with 2 years training who are supervised by public health dentists. Both countries have virtually eliminated tooth loss in elementary school children by timely examination and filling of teeth.

Most countries that have decided to provide dental care for children in recent years have adopted the New Zealand model with appropriate modifications. Although demonstration projects in the United States have affirmed the feasibility of training this type of paraprofessional, organized dentistry has prevented further experimentation and development. Although I and many of my colleagues advocate adoption of the New Zealand school dental nurse system, we are more concerned that a school-based program be established regardless of the professional staffing pattern. But it is not inappropriate to point out that there are 85,000 elementary schools in the United States and approximately the same number of practicing dentists. Staffing a school-based program primarily with dentists might well deprive the ambulatory adult population of needed care. To me it is too much like "robbing Peter to pay Paul." Nonetheless, well-trained dentists utilizing a number of expanded duty dental assistants may very well provide the necessary school services in those areas with a heavy concentration of dentists. If we truly support the concept of pluralism, then we should be willing to develop a number of models not only to provide services but also to allow comparisons of costs and effectiveness for future guidance.

I submit, Mr. Chairman, that the dental profession which claims to have sufficient capability, be given the opportunity to prove its case. But if this capability is found wanting, then the profession should not be allowed to stand in the way of developing not only an alternate delivery system but also alternate paraprofessional personnel. This principle should be part of the mandate for including children's dental care in National Health Insurance.

4. A SCHOOL-BASED DENTAL PROGRAM FOR CHILDREN

Accessibility—both financial and physical—is the key to the success of any health care program. By placing facilities and personnel directly in schools, the entire school population can be reached. Considering the magnitude of the task, it will be necessary to phase in the children incrementally for direct care such as filling of decayed teeth. However, primary preventive care can be provided the entire school population at the outset of the program.

Certain types of preventive services do not require the services of dentists or school dental nurses (therapists). For example, special auxiliaries trained in a few week's time can teach toothbrushing, flossing of the teeth, and good diet. They can also supervise the administration of fluoride mouth rinses by students themselves. These rinses or gels can be dispensed to entire classrooms of children at frequent intervals to maximize the prevention of cavities. Pit and fissure sealants can be applied to individual students by these auxiliaries under the supervision of dentists, dental hygienists and school dental nurses. Student leaders can participate in these educational and "treatment" procedures, encouraging participation among their peers.

Since it would be impossible to provide fillings for all children at once, priorities must be established. At the outset, we recommend the program begin with two age groups—6–7 year olds and 10–11 year olds. Time does not permit description of the rationale for this selection. Suffice it to say that we believe such an approach maximizes long-term results because it is at these ages that the permanent molars can be best protected. In subsequent years the other age groups would be added incrementally until the entire school population is included.

Let me emphasize again, Mr. Chairman, that this recommendation is for prevention—primary and secondary prevention. Unless prevention is practiced on a continuous basis throughout the life of the individual, much effort and money will have been wasted. This has been the experience of many well-intentioned programs such as Headstart which offer the children neither follow-up nor continuity. It has been the experience of programs the offer only primary prevention—health education and topical fluorides—but which fail to carry through with secondary preventive procedures such as fillings to prevent tooth loss.

Only basic dental care need be provided in the school clinics. Children with special dental problems will be referred to private dentists. Thus, the private sector will supplement the school program. This point is extremely important because the success of a school-based program is linked to the acceptability, cooperation, and participation of private dental practitioners.

What would be the cost of such a program? In Saskatchewan where a school-based program utilizing New Zealand-type dental nurses has completed its first year of operation, costs are estimated at about $35 per child. In our proposal for a similar pilot project a few years back, Dr. John I. Ingle, (former Dean of the University of Southern California School of Dentistry and now with the National Academy of Sciences Institute of Medicine), and I came up with a similar estimate, amortizing start-up costs of training and equipping the clinics over a ten-year period. At current dental fees, a single visit to a private dentist would cost that much just for examination, cleaning and X-rays. With four or five fillings, the cost could easily exceed $100. Thus, a school-based program would save up to 65% of the cost for the same services provided by private dentists.

I believe this same estimate of costs should be applied whether dental nurses or dentists are the primary providers in the school clinics. Where dentists are employed along with multiple expanded function dental assistants, their productivity has been increased by as much as 400%. As important as cost-savings are, even more important would be the provision, for the first time in the history of our nation, of needed dental care for the majority of our children.

Needless to say, participation in the program would require the voluntary consent of parents. Experience in other countries and in pilot projects in this country have demonstrated virtually complete acceptance by parents, by teachers, and most important, by children.

5. EFFECT ON ADULT DENTAL CARE

Parents would be relieved of the enormous burden of out-of-pocket expenditures once the program was in full swing. More money would thus be available for their own dental care. Far from incurring loss of income, dentists have everything to gain from supporting a school-based program.

A later effect would be the enlargement of the older population that would continue to receive periodic dental care, as children become adults. Studies of the New Zealand population have demonstrated a continually increasing utilization of private dentists and a corresponding decrease in tooth loss and the number of denture wearers.

Furthermore, overall expenditures are reduced when maintenance care is provided on a continual basis. The amount of time required to maintain patients in good health is perhaps a third or less than the time required to repair the ravages of years of neglect.

When we speak of a school-based program for children, we are also addressing the long-term dental health care needs of the adult population as well.

6. MAINTAINING TITLE 19 DENTAL BENEFIT PROGRAMS

In the least, present levels of care provided recipients of state aid programs should be maintained. Those states which presently provide little or no benefits should be required to meet acceptable levels of care if they are to receive National Health Insurance support for a school-based children's program. Since a large portion of Title 19 dental funds are expended for children's care, relief from this burden should allow increased dental benefits for the adult population.

CONCLUSION

1. The existing dental care delivery system in the United States is inadequate to meet the entire needs of the population.
2. A school-based preventive dental care program is a practical means of assuring that children receive essential care.
3. For dental care to be provided efficiently, effectively, and economically under National Health Insurance, unrestricted development and utilization of auxiliary or paradental personnel must be encouraged if not mandated in supervised environments such as school clinics.
4. The time has long since passed when further delays can be justified. Dental care for children must be included in the first enactment of National Health Insurance.

Thank you, Mr. Chairman and members of the committee, for the opportunity to make this presentation.

U.S. ADMINISTRATORS,
Beverly Hills, Calif., November 19, 1975.

Re addendum to testimony presented before the subcommittee November 18, 1975, by Dr. Jay W. Friedman, DDS, MPH.

Representative DAN ROSTENKOWSKI,
Chairman, Subcommittee on Health,
Committee on Ways and Means,
Washington, D.C.

MR. CHAIRMAN: As an addendum to my prepared statement of November 18th, I submit the following remarks.

Most advocates of a children's dental care program recognize the existence of an enormous "backlog of need." Therefore the usual recommendation is to approach this need incrementally, beginning with specific age groups (ex. 6–7, 10–11) and filling in the intervening ages as the program progresses. This concept is based on the all-or-none principle of providing "comprehensive" services to those children who can be treated with available resources. It has a major disadvantage in that many children who would not be covered initially would nonetheless have large open cavities and toothaches.

Another approach to incremental coverage is to consider not age per se but priority of need. By examining all the children in a particular school, those individuals with the most urgent conditions would receive first treatment, regardless of age. The initial treatment need not even consist of permanent fillings. Semi-permanent sedative-resin fillings (IRM) have been developed which can last one or two years, protecting the teeth from further decay, and relieving the child of pain and potential infection. For some teeth like deciduous (baby) molars which exfoliate naturally, these temporizing fillings may be all that is necessary, thus representing also an important economy in the service. When all the children have received this basic service, more permanent restorations can be placed as necessary.

Basing the initial program on priority of need rather than incremental age groups is an answer to the questions, "Who shall receive care? Who shall be neglected?" The answer is that everyone would receive care with determination on the basis of real need rather than neglecting some by arbitrary age designation.

This type of priority system has been employed in a number of group practices that have undertaken the care of large numbers of beneficiaries with limited personnel and fiscal resources. It is a realistic approach to the problem that merits further consideration for a school-based children's dental care program.

Sincerely yours,

JAY W. FREIDMAN, D.D.S., M.P.H.,
Dental Director.

Mr. ROSTENKOWSKI. Thank you, Dr. Friedman.

Dr. Lobene.

STATEMENT OF RALPH R. LOBENE, D.D.S.

Dr. LOBENE. Mr. Chairman, I am Ralph Lobene, dean, Forsyth School for Dental Hygienists, and the project director.

I have an edited version of a statement I would like to have entered in the record which deals with the findings of our research study.

The delivery of dental care has not developed to meet the existing needs, but rather has evolved to meet the demand for dental care. Reduced to simple terms, this system has responded to the ability to pay. With the inclusion of dental benefits as a fringe benefit for an ever-increasing number of workers, the development of third-party payments system, the inclusion of limited dental benefits in medicare and medicaid programs, there is a need to examine the cost of dental benefit programs to serve the existing unmet dental needs. Consequently, the Forsyth Dental Center launched a search for an answer.

The rationale for the Forsyth study was that a significant increase in the individual dentist's capacity to provide more high-quality dental care to more people at the lowest possible cost could be achieved by greater utilization of trained auxiliaries. Furthermore, we concentrated on restorative dentistry because restorative services make up the bulk of the public's demand for dental care and this is where the use of advanced skills hygienists can have the greatest impact on costs. In addition, these programs would probably focus on children, for whom dental decay is the greatest problem.

The findings of our study leave little doubt that the utilization of advanced skills dental hygienists can provide more high-quality dental care for more people at lower costs.

One: A total of 2,668 patients were treated during the study. Most were between 5 to 35 years of age because 60 to 80 percent of a general dentist's practice is spent in prophylaxis, prevention, and drilling and filling teeth in this age group.

Two: Working under the direct supervision of a dentist, routine monitoring of quality during 15 months of experimental clinical practice showed that 96 percent of the cavity preparations and 98 percent of restorations executed by advanced skills hygienists met all standards for acceptable restorative dentistry. The quality of restorations was higher than that generally provided by the dental profession not working under some form of quality control as determined by the use of radiographs. Overhanging margins on restorations by advanced skills hygienists were detected in 5.1 percent of the cases examined. A similar study of dentists not working under quality control surveillance showed 30 percent overhanging margins.

Three: Administration of injections by registered nurses is routinely accepted by the medical profession, but hygienists have not been permitted this function in dentistry. A total of 19,173 injections of local infiltrations and block anesthetics were administered by advanced skills hygienists during the 3 years with only three minor reversible reactions.

Four: Of the patients screened and examined for admission to the project, only 10 percent needed to be rejected because their oral health problems were so severe that they could not benefit significantly from services which could be provided by the advanced skills hygienists. The advanced skills hygienists treated 90 percent of the patients screened and only 1.3 percent of the patients surveyed expressed any negative comments. It was found that the advanced skills hygienists could be a valuable addition to most dental practices.

Five: It was found that one dentist can properly utilize two advanced skills hygienists/dental assistant teams by devoting only 14 percent of his time to supervision. This permits the dentist ample time to deal with more involved dental work. The gross income of this experimental private practice was increased by 51 percent and the net income by 100 percent.

One advanced skills hygienist/dental assistant team of auxiliaries could generate a gross income for the practice of $43,000 with a net income after all expenses of 51 percent of gross using usual and customary fees. This leads us to believe that costs to the public could be reduced approximately 25 percent by using these auxiliaries.

The findings of this study relative to productivity and income support the conclusion that the use of advanced skills hygienists/dental assistant teams working under the direct supervision of dentists should enable the dental profession to deliver more high-quality restorative dentistry to more people for less cost than if the dentist provides this care with his own hands.

Based upon these facts, I make the following recommendations as guidelines for the inclusion of dental benefits in any form of national health insurance:

One: Legislation should in no way destroy the existing pluralistic system for the delivery of dental care—private solo practice, group practice, clinical practice, and institutional practice. However, in a free enterprise system these modes for delivery of dental health care should be competitive.

Two: The first priority for the provision of care should be for children up to age 17. The eligibility should be staggered so as to provide for an even flow of patients into the care system. Care could be provided in school clinics or by the private practitioners.

Three: In the provision of care either by the private sector or by other systems, maximum use of dental auxiliaries must be part of the plan if the cost of care is to be contained at reasonable levels.

Four: The implementation of dental care systems should not destroy any existing methods for the payment of care.

Five: Recognizing the existence of a maldistribution of dentists and dental auxiliaries, consideration should be given to a system of tax forgiveness for 5 years as an incentive to dental practitioners to locate in underserved areas and to remain there.

Six: A national educational effort should be made to inform the people of the United States of the fact that most dental disease is preventable. This effort should begin in the schools and should extend into the community and the homes.

In providing these health benefits we must include prevention and utilization of dental auxiliaries in the delivery of care if our programs are to be cost effective. The dental profession, at all levels, must clearly recognize its obligation to reduce costs.

Dr. I. Lawrence Kerr, a distinguished dental practitioner and trustee of the Second District, American Dental Association, made this point in an address to the USPH Division of Dentistry Workshop on "Changing Roles of Dental Auxiliaries" in June 1975. He said: "Savings that may accrue as a result of alteration of the present system must be passed to the patient. Or eventually the ogre of rate regulation and system control will take over."

I firmly believe we now can and should afford these oral health benefits for our people.

Mr. Chairman, I wish to thank the committee for the opportunity to make this statement.

[The prepared statement and attachment follow:]

Statement by Dr. Ralph R. Lobene, Dean, Forsyth School for Dental Hygienists, Forsyth Dental Center, Boston, Mass.

In the long run, the nature of the oral health problems of the people of the United States will shape the future system developed to meet these dental needs and will determine how, where and for whom dental benefits will be included in National Health Insurance. Oral diseases are not self limiting, they are chronic and not subject to curing themselves. Consequently, the need for improved prevention and treatment of unmet dental needs is common to all of our people. In a recent report (J.A.D.A. 84:1073–1075, May, 1972) Dr. Greene pointed out that the largest, costliest unmet neet in the entire health field is the need for dental care. During 1974, the American people spent in excess of 5 billion dollars for dental care. Yet only 25 percent of the total population rceeived comprehensive dental care while another 25 percent sought emergency dental care.

The delivery of dental care has not developed to meet the existing needs, but rather has evolved to meet the demand for dental care. Reduced to simple terms. this system has responded to the ability to pay. With the inclusion of dental benefits as a fringe benefit for an ever increasing number of workers, the development of third party payments system, the inclusion of limited dental benefits in Medicare and Medicaid programs, there is a need to examine the cost of dental benefit programs to serve the existing unmet dental needs. Consequently, the Forsyth Dental Center launched a search for an answer.

The rationale for the Forsyth study was that a significant increase in the individual dentist's capacity to provide more high quality dental care to more people at the lowest possible cost could be achieved by greater utilization of trained auxiliaries. Furthermore, we concentrated on restorative dentistry because restorative services make-up the bulk of the public's demand for dental care and this is where the use of advanced skills hygienists can have the greatest impact on costs. In addition, these programs would probably focus on children, for whom dental decay is the greatest problem.

The findings of our study leave little doubt that the utilization of advanced skills dental hygienists can provide more high quality dental care for more people at lower costs.

1. A total of 2,668 patients were treated during the study. Most were between 5 to 35 years of age because 60 to 80 percent of a general dentist's practice is spent in prophylaxis, prevention and drilling and filling teeth in this group.
2. Working under the direct supervision of a dentist, routine monitoring of quality during fifteen months of experimental clinical practice showed that 96 percent of the cavity preparations and 98 percent of restorations executed by advanced skills hygientists met all standards for acceptable restorative dentistry. The quality of restorations was higher than that generally provided by

the dental profession not working under some form of quality control as determined by the use of radiographs. Overhanging margins on restorations by advanced skills hygientists were detected in 5.1 percent of the cases examined. A similar study of dentists showed 30 percent overhanging margins.

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4. Of the patients screened and examined for admission to the project, only 10 percent needed to be rejected because their oral health problems were so severe that they could not benefit significantly from services which could be provided by the Advanced Skills Hygienists. The Advanced Skills Hygienists treated 90 percent of the patients screened and only 1.3 percent of the patients surveyed expressed any negative comments. It was found that the Advanced Skills Hygienists could be a valuable addition to most dental practices.

5. It was found that one dentist can properly utilize two advanced skills hygienists—dental assistant teams by devoting only 14 percent of his time to supervision. This permits the dentist ample time to deal with more involved dental work. The gross income of this experimental private practice was increased by 51 percent and the net income by 100 percent. One advanced skills hygienist-dental assistant team of auxiliaries could generate a gross income for the practice of $43,000 with a net income after all expenses of 51 percent of gross using usual fees.

The findings of this study relative to productivity and income support the conclusion that the use of advanced skills hygienists-dental assistant teams working under the direct supervision of dentists should enable the dental profession to deliver more high quality restorative dentistry to more people for less cost than if the dentist provides this care with his own hands.

Based upon these facts, I make the following recommendations as guidelines for the inclusion of dental benefits in any form of National Health Insurance.

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2. The first priority for the provision of care should be for children up to age seventeen. The eligibility should be staggered so as to provide for an even flow of patients into the care system. Care could be provided in school clinics or by the private practitioners.

3. In the provision of care either by the private sector or by other systems, maximum use of dental auxiliaries must be part of the plan if the cost of care is to be contained at reasonable levels.

4. The implementation of dental care systems should not destroy any existing methods for the payment of care.

5. Recognizing the existance of a maldistribution of dentists and dental auxiliaries, consideration should be given to a system of tax forgiveness for five years as an incentive to dental practitioners to locate in underserved areas and to remain there.

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In providing these health benefits we must include prevention and utilization of dental auxiliaries in the delivery of care if our programs are to be cost effective. The dental profession, at all levels must clearly recognize its obligations to reduce costs. Dr. I. Lawrence Kerr, a distinguished dental practitioner and trustee of the Second District, American Dental Association made this point in an address to the USPH Division of Dentistry Workshop on Changing Roles of Dental Auxiliaries in June 1975. He said, "Savings that may accrue as a result of alteration of the present system must be passed to the patient. Or eventually the ogre of rate regulation and system control will take over." I firmly believe we now can and should afford these oral health benefits for our people.

Mr. Chairman, I wish to thank the committee for the opportunity to make this statement.

FINAL REPORT

A STUDY OF NEW DUTIES FOR DENTAL HYGIENISTS, RALPH R. LOBENE, D.D.S., M.S.

1. INTRODUCTION

This report of the final phases of the Forsyth Study of New Duties for Dental Hygienists (Project Rotunda) will provide data on the internship and clinical practice completed by the advanced skills hygienist (ASH) dental assistant (DA) teams. Evaluations made of the clinical practice productivity and income of ASH–DA teams, who always worked under the direct supervision of and at the direction of the dentist, are also reported. These experiments attempted to parallel, whenever possible, conditions as they exist in most solo private dental practices of today. Consequently they centered on the use of single and multiple auxiliary teams working with a single dentist. Delivery of dental care under clinic like conditions was also studied.

From each experiment, data were compiled on the quality, quantity and the income which could have resulted from the use of various combinations of ASH–DA teams if the patients had been billed for services. The income resulting from the various experiments was derived by the use of welfare and usual fee schedules since the patients participating in these experiments in the delivery of dental care were provided care free of charge. The data on income was used to cost account the experimental practices studied in order to determine the potential impact the use of ASH–DA teams may have on the cost of restorative dental services delivered to the public. Quality was also continuously monitored by extramural examiners and daily by supervising dentists. These data on the quality of care, the positive economic feasibility for use of ASH and the overwhelming public acceptance of the ASH, could provide the guidelines to the dental profession for implementation of such a system in the private sector.

The instruments designed for reporting findings, measuring quality and quantity of services provided, time motion of dentist and auxiliary teams and acceptance of ASH by patients have been described in great detail in previous reports (J. Dent. Ed. 38:369, 1974; Proposal Robert Wood Johnson Foundation, May, 1973). Consequently, this detailed methodology will not be repeated here.

2. ORGANIZATION STRUCTURE—PROJECT ROTUNDA

Project director: Ralph R. Lobene, B.S., D.D.S., M.S.

Assistant project director: Lloyd B. Chaisson, B.Sc., D.D.S.

Staff dentists: Roy A. Colella, B.S., D.D.S.; Melvin Gulbrandson, B.S., D.D.S.; Minoru Horiuchi, D.D.S., D.M.D.; George L. Keleher, B.S., D.D.S.; Leonard F. Nolan, B.S., D.M.D.

Administrative assistant: Mary B. Newman, R.D.H., B.S.

Supervisor auxiliaries: Maureen McCarthy, C.D.A., R.D.H., A.S.

Secretary: Leslie Levitt.

Advanced skills hygienists: Lorna Bronhard, Maryann Carrazza, Kathy Daley, Christel M. Koppel, Barbara McCormack, Lisa O'Laughlin, Marcia Seltzer, Cheryl Singer, Constance Stone, Denise Vezina.

Dental assistants: Denise Anderson, Willie Brooks, Susan Jenkins, Marilyn Keenan, Carol Lund, Denise Meehan, Carol Mucci, Patricia McGoldrick, Eileen Regan, Ellen Roberts, Susan Palmieri, Lynn Scaffidi, Maureen Sullivan.

3. OVERVIEW OF THE FORSYTH STUDY OF NEW DUTIES FOR DENTAL HYGIENISTS

Forsyth was a pioneer in research in the United States into new duties for dental hygienists as a way of providing adequate dental care for the U.S. population. In 1949, the Forsyth Dental Center established such a training program which was aborted by action of the Massachusetts legislature which reacted to charges by the dental profession, that expanded duties dental hygienists would result in second level lower quality dentistry. Twenty-one years later, in January, 1970, the House of Delegates of the Massachusetts Dental Society gave approval to and encouraged experimental studies related to expanded functions for auxiliaries. The dental society and the State Board of Dental Examiners were informed by Forsyth that a research project was to be undertaken at Forsyth to determine, once and for all, is the graduate hygienist could be trained to do simple restorative dentistry, specifically the drilling and filling of teeth.

In June, 1971, plans were made at Forsyth to design and equip a modern dental facility (The Rotunda) to instruct graduate dental hygienists in restorative dentistry (drilling and filling) and to train them so that their skills would equal the dentist's. This new clinical research facility was constructed with funding coming from a grant from the Frederick J. Kennedy Memorial Foundation. This research project would also seek to determine if use of expanded duties dental hygienists could lower the cost of high quality dental care provide to the public. The Forsyth study became known by the code name Project Rotunda.

In March of 1972, ten hygienists who were 1971 graduates of two year hygiene schools began didactic and preclinical training in restorative dentistry. After successful completion of preclinical training with manikins, these hygienists began work with patients under the clinical teaching of staff dentists qualified as clinical teachers. Upon completion of the internship phase of clinical practice, their work was evaluated by the Special Forsyth Liaison Committee of the Massachusetts Dental Society and they were found to have the equivalent skills of graduate dentists in the area of restorative dentistry. Subsequently, extramural examiners participated in two additional evaluations with the same outcome.

The studies in this research project in the delivery of dental care completed up to this point had demonstrated that it is possible to teach restorative dentistry to individuals with a background in dental hygiene in only 25 weeks. It is important to note that this additional training could readily be incorporated into a two year hygiene curriculum by revising the existing curriculum. While this certainly was an important goal of the research, it was still necessary to objectively determine the most effective combination of dentists, advanced skills hygienists (ASH), dental assistants (DA) and other support personnel necessary to deliver more high quality dental care to more people at the lowest possible cost. These studies which paralleled private practice also provide data which can be extrapolated to determine the feasibility of the private sector of dental practice to meet this challenge.

4. SUMMARY OF KEY EVENTS COVERED IN THIS REPORT FROM SEPTEMBER, 1972, TO JUNE, 1974, WHEN THE STUDY WAS TERMINATED

September 1972—Certified chairside dental assistants and the advanced skills hygienists began training in four handed dentistry to deliver restorative dental services.

October 1972—The teams of advanced skills hygienists and chairside dental assistants working under the direct supervision of staff dentists began the internship phase of clinical practice. Individual team productivity was measured through January, 1973.

February 1973—The internship phase of clinical practice was completed.

March 1973—Shortly after the completion of the internship phase of clinical practice the first of three evaluations by extramural examiners of the quality of the restorative procedures completed by ASH was held. This evaluation was conducted by the Massachusetts Dental Society Forsyth Special Liaison Committee. The first time and motion studies of the use of ASH–DA teams in the delivery of care began.

May 1973—The experimentation with private practice to determine the most effective combination of dentists, advanced skills hygienists and dental assistants began. The combination of mixes studied were:

a. Team of two advanced skills hygienists and one dentist working with three operatories.

b. Team of three advanced skills hygienists and one dentist working with four operatories.

c. Team of five advanced skills hygienists and one dentist working with six operatories.

The quality, quantity, income and cost of dental care provided by dentists and teams of advanced skills hygienists was studied during this period. The optimum combination of personnel for providing the optmium dental services in an experimental practice simulation was determined. These studies continued until May, 1974.

June 1973—The second evaluation of quality of services provided by ASH was conducted by extramural examiners of the Massachusetts Dental Society Forsyth Special Liaison Committee.

March 1974—The third evaluation of the quality of restorative dentistry provided by ASH was completed by a group of extramural examiners who were teaching restorative dentistry at Tufts, Harvard and Boston University Schools of Dental Medicine.

June 1974—Based upon an opinion of the Massachusetts Attorney General's Office and pressure from the Board of Dental Examiners, the Forsyth Study of New Duties for Dental Hygienists (Project Rotunda) was terminated.

5. SUMMARY OF FINDINGS AND CONCLUSIONS OF THE FORSYTH STUDY OF NEW DUTIES FOR DENTAL HYGIENISTS

A. Findings related to quality

1. On the basis of three blind examinations by teams of independent dental examiners, the ASH were found to perform restorative dentistry equal in quality to that performed by practicing dentists also working under the restraints of quality control.

2. Routine monitoring of quality during the fifteen months of experimental clinical practice showed that 96% of the cavity preparations and 98% of the restorations performed by ASH's met all standards for acceptable restorative dentistry as established for this study. The remainder of the cavity preparations and restorations only required either the judgment or direct intervention of the dentist to bring them to the acceptable standard.

3. A third evaluation for quality of restorative dental services was the evaluation of 20.8 percent of the patients selected at random at time of recall for the presence of overhanging margins. In only 5.1 percent of this sample (3,743 interproximal amalgam restorations) were overhanging margins detected by use of bite wing radiographs. This finding compares with a level of 30 percent overhanging margins found in the study of young adult patients in Massachusetts performed in 1967.

4. Monitoring of the administrations of both infiltration and mandibular block anesthesia throughout the study, revealed that infiltration anesthesia was administered successfully on the first attempt 97 percent of the time. Mandibular block anesthesia was successfully administered on the first attempt 86 percent of the time. The 19,173 local anesthetics administered by the ASH's resulted in only 3 adverse reactions which were minor short term paresthesias. In approximately 1 percent of the cases, the intervention of the supervising dentist was required to achieve an acceptable level of anesthesia.

B. Findings related to acceptability

1. Of a total of 2,980 patients screened and examined for admission to the project, only 10.5 percent needed to be rejected because their oral health problems were so severe that they could not benefit significantly from services which could be provided by the ASH's.

2. Forty-five percent of the 2,668 people who received a full course of treatment within the scope of the project volunteered to express an opinion on their satisfaction with treatment provided by the project.

3. Ninety-nine percent of the 1,200 volunteered opinions were favorable concerning the patient's perception of competence of the operator or the quality of treatment received, 99 percent indicated they would choose the same individuals to do more of their dental work, 39 percent indicated they were uncertain as to the type of dental personnel who provided the work, 46 percent guessed correctly that an ASH had provided their therapy, and 1 percent stated a preference for treatment by a male.

C. Findings related to solo practice

1. One dentist can supervise 10 ASH–DA teams delivering restorative dental care as long as the dentist is not required to perform diagnosis, treament planning or any other direct patient services.

2. One dentist cannot supervise 5 ASH–DA teams delivering restorative dental care and have sufficient time to adequately perform diagnoses, treatment plans, or other significant patient services.

3. One dentist can supervise 2 ASH–DA teams delivering restorative dental care and have 86 percent of the work day available in blocks of free time adequate for the performance of diagnoses, treatment plans, and other significant patient services, while with 1 ASH–DA team the dentist had 93 percent of his time free.

D. Findings related to productivity and income

1. The ASH–DA teams were performing services in direct patient contact an average of 61 percent of their work time regardless of the dentist-ASH–DA teams configurations.

2. The patient's appointment time spent with ASH–DA teams averaged 45 minutes.

3. The percentage of a dentist's work time to appropriately supervise one team was 7 percent and for two teams 14 percent.

4. The gross income per hour generated by single ASH–DA teams for all services provided during the entire clinical practice phase averaged $26.31 per hour per team by welfare fees and $39.12 per hour per team by usual fees.

5. The gross income per hour generated by a solo dentist providing dental care while supervising one or two ASH–DA teams ranged from $12.50 to $72.73 per hour by welfare fees and $26.29 to $90.98 per hour by usual fees, and averaged $38.01 and $56.97 per hour by welfare and usual fees, respectively.

6. On the basis of a 10 percent sample of actual services rendered while operating experimental private practices consisting of one dentist and one ASH–DA team and of one dentist and two ASH–DA teams, the net income to the practices after expenses, were 30 percent to 34 percent of the total gross income by welfare fees and 46 percent to 51 percent by usual fees.

E. Conclusions

Under the conditions of this experimental study of new duties for dental hygienists, the data and findings support these conclusions:

1. The services provided by ASH's working under the direct supervision of the dentist were of high quality.

2. The quality of restorations delivered by appropriately supervised ASH–DA teams was higher than that generally provided by the dental profession not working under some form of quality control.

3. The administration of local anesthetics by ASH's working under the direction of and upon prescription of a dentist was safe and effective.

4. Since 90 percent of patients drawn from a caries susceptible population and in the age range of 5 to 35 were found capable of benefiting from the services performed by advanced skills hygienists, the ASH could be a useful addition to a general practice or clinic providing dental care for a large number of caries susceptable people.

5. There was a high level of patient satisfaction (98.8 percent) with the dental services provided by the ASH–DA teams.

6. A dentist practicing in a solo setting should not be permitted to supervise more than two ASH–DA teams.

7. Since any return on safe investments in excess of 15 percent is most unusual, the findings of this study strongly suggest that the use of ASH–DA teams offers the dental profession attractive avenues for providing the public high quality restorative dentistry in a more economical fashion.

Mr. ROSTENKOWSKI. Thank you, Dr. Lobene.

Dr. Williams?

STATEMENT OF CHARLES E. WILLIAMS, JR., D.D.S.

Dr. WILLIAMS. Mr. Chairman, members of the committee, I am Dr. Charles E. Williams, Jr., of Chicago, Ill., president of the National Dental Association; an organization that is the principal provider of dental care for the Nation's 25 million black citizens.

This responsibility is not taken lightly by our members who are located in nearly all 50 States and territories. Since our inception in 1918, the National Dental Association has always been striving to maintain as its goal the reduction of human suffering from dental disease, the education of the population toward prevention of the ravages of dental diseases and the constant improvement and upgrading of our professional abilities. Our standards have always been to provide the highest quality of services to patients we serve, maintaining ethical procedures, and integrity of character.

As a national organization, the National Dental Association is concerned about the dental health of all citizens, regardless of their geographic location, ethnic origin, age, or sex. We believe that the dental profession should take an active role and be involved at all levels in the design and the implementation of a national health insurance that includes a dental program that realistically and truly provides the needed dental service to all people of this Nation.

However, we hasten to state that consideration must be given to the poor, the minorities and those who fall between the designation of poverty and affluence but have limited resources to purchase required dental services.

The National Dental Association supports the proposal and the enactment of a national health program that will insure equal and adequate dental care for all Americans.

The National Dental Association supports the concept of a national health insurance. It is our position that if we as dentists proclaim that dental health is an essential health service, it should be available to all segments of the population. Traditionally, token programs of dental treatment designed for lower income patients have been limited in their scope of services, which has served as a source of frustration to the practitioner in an attempt to deliver adequate treatment.

We recommend: National comprehensive health insurance program which includes complete dental care without limitations as age, income, et cetera. Comprehensive dental health care includes the following: (1) Preventive and health education measures for the consumer; (2) periodic diagnostic examination of the oral cavity; (3) elimination of infection and life-threatening oral diseases; (4) immediate treatment of injuries and diseases of the hard and soft tissues; (5) restoration of nonfunctional and abnormal teeth; and (6) maintenance of normal relationship and function of permanent teeth.

The national health insurance is a feasible financing mechanism for dental health care and should include special financial consideration for poor blacks and other minorities. It is recommended that appropriate payment mechanisms be used. It will be necessary to develop programs to increase the efficient use of manpower and facilities presently available.

We have confidence that priorities will be evident and will be established for immediate service. Prompt increases in training and education of needed health person power will be evident by the obligations of the new program. Funds for such increases in education and training must be part of the national health insurance program.

The National Dental Association has the responsibility to understand and to promote a comprehensive health plan and it assumes the responsibility of informing practitioners of the positiveness of national health insurance programs so that they will become allies in the effort.

We feel that it is fairly safe to assume that during this session of Congress or in coming sessions, a national health insurance package will be passed. We invite the American Dental Association to join us in developing the type of dental benefit package that will best suit the needs of our patients and our fellow practitioners.

For any health care legislation to have significant and fruitful long-range results, this country, of necessity must reorder and reconstitute its priorities in such a manner that it considers first and foremost the health care of its citizens, cost notwithstanding. The Nation pays for everything else. I, therefore, predict that it is ready and willing to pay for better health care. Therefore, I am asking for a health plan so designed that it will assure health care for all Americans as a top priority

The following is an addendum to the above statement taken from the National Dental Association "Charet," "The Status of Dental Health in the Black Community." A "charet" loosely interpreted means a discussion session. The statement in this charet have been agreed upon and passed by the House of Delegates of the National Dental Association.

The NDA recognizes that a ratio of one dentist to 2,000 people may be attainable in the white community, nothing short of a miracle can transform the current one black dentist to 10,000 to 12,000 black citizens into a realistic and workable ratio. In a national health program, we hope that some positive change can occur to vastly increase black dental manpower to minister to the health needs of all Americans. This will mean special planning to bring the number of professionals and paraprofessionals to a more equitable level. The black dentist has served on a rural frontier as well as the ghettos and barrios of our Nation without complaint. He has served with little input into the planning of how that Nation, States and localities can better address themselves to solving the problems that overwhelm him and the communities where his services are rendered.

The requisites for an adequate national dental health program will have to make special dispensation and funding for a better dental manpower ratio and a more holistic approach to the delivery of dental service to black and minority populations.

We feel these requisites fall into two categories:

One: Minimum elements of a National Health Insurance. We are certain that the committee is currently aware that no health program should be considered complete without the inclusion of dentistry. And, no dental program is comprehensive without key items of service and adequate funding. These essential services include:

(*a*) Twenty-four hour emergency dental service for all citizens through the incorporation of dental care services as a component of all health facilities.

(*b*) Comprehensive dental service with special emphasis on preventive measures and patient education, because in the urban ghetto communities and rural areas ill health and ignorance thrive.

(*c*) Complete and comprehensive dental care services that are a part of the basic comprehensive health package essential to the general health of the total population.

(*d*) A clearly identifiable dental budget that reflects the special dental health needs and allows for the correction of past destruction of human tissues and organs. This budget should be approximately 15 percent of the total health dollar.

A. MANPOWER AND DEVELOPMENT OF HUMAN RESOURCES

Two: Areas of special stress. As previously indicated the storage of black dental professionals and paraprofessionals is as critical and as overwhelming as the existence of dental disease. Therefore, direct and positive steps must be incorporated into any national health program that gives special emphasis to the solution of this problem. The NDA recommends that it be done through the following mechanisms:

(i) The increase in the numbers of black dental professionals and allied health personnel through special recruitment, financial support, and economic incentives to return to underserved areas. This step is essential to overcoming the massive backlog of chronic dental disease in most minority and poor white ghetto and rural communities.

(ii) Special Federal grants for minority student assistance associated with appropriate curriculum development in schools which train dental personnel. This effort should be combined with plans to promote community involvement in the planning, decisionmaking, and delivery of dental services to community residents.

Mr. DUNCAN [presiding]. Dr. Williams, we are having a rollcall. We will suspend for 2 or 3 minutes. The chairman will be back soon.

[A brief recess is taken.]

Mr. ROSTENKOWSKI. The subcommittee will resume its hearing.

Dr. WILLIAMS. I will resume with No. 3 of my statement.

Three: The training of black and other minority persons for teaching, research and administration. This should be accomplished with special remedial programs necessary to insure graduation of all minority persons entering training for that dental field assuming they show promise for development. It should further provide for the development of challenge, proficiency and equivalency examinations based on ability to perform dental tasks.

Four: The elimination of dead end job categories for the allied dental health personnel through the development of a basic dental core curricula as an entree into the profession. This core of health knowledge should be embellished to incorporate needed knowledge and skills to assure long-term development and career ladders and lattices in the dental profession.

Five: Special training programs in dental schools, junior colleges and other institutions of learning that will capitalize on the previous experience and training of black and minority veterans of the U.S. armed service so as to incorporate them, as quickly as possible, into the dental care delivery program. Further, that they and all newly trained allied personnel be taught extended and expanded functions in the delivery of dental services.

Six: Special funds be made available to institutions significantly increasing the number of black and minority students in their student body.

B. PUBLIC POLICY AND CONTROL

As a matter of public concern, the Federal Government must maintain final responsibility for the development, perpetration and enforcement of public policy regarding a national health system. The guidelines that it established should give significant consideration and credence to our national goals of health as a right to all our citizens.

C. SPECIAL SUPPORT AND DISTRIBUTION NEEDS

Over and above the allocation of funds for routine implementation of a nation's dental health program, special funding should be made available to promote the development of minority persons in dental health careers.

Mr. Chairman, thank you for the privilege of presenting these facts before you.

Mr. Rostenkowski. Thank you, Doctor.

Dr. Deputy?

STATEMENT OF BYARD DEPUTY, D.D.S.

Dr. Deputy. Mr. Chairman, members of the committee, I am Byard S. Deputy, associate professor, Division of Dentistry, University of Virginia.

In response to your invitation, I welcome the opportunity to submit a statement to members of the Subcommittee on Health of the House Committee on Ways and Means.

In addition to other duties at the University of Virginia Medical Center, I am project director of the Greene County Dental Health of Children Project, Greene County, Va. In the brief time assigned to me, I want to give you some of the background of the pilot programs in children's dental health—Greene County was one of the original seven; the planning and implementation of the project; and some of the operational data that we have procured.

The Child Health Act of 1967 provided a new authorization for project grants for dental health of children and read as follows:

> In order to promote the dental health of children and youth of school or preschool age, particularly in areas with concentrations of low-income families, the Secretary (HEW) is authorized to make grants—to pay not to exceed 75 percent of the costs of projects of a comprehensive nature for dental care and services for children and youth of school age or preschool children. No project shall be eligible for a grant under this section unless it provides that any treatment, correction of defects, or aftercare provided under the project is available only to children who would not otherwise receive it because they are from a low-income family or for other reasons beyond their control.
>
> The major objective of project grants for dental health of children was to develop pilot programs which would provide comprehensive dental services for children who otherwise would not have received care. The grants were to increase the availability and to improve the quality of services necessary to prevent disease and to restore and maintain oral health. Project grants were not to replace or reduce State or local community funds.

Being associated with the University of Virginia's comprehensive child care program in adjacent Albemarle County at that time and knowing the need for dental care in Greene County, we pursued one of these grants for children's dental health with considerable vigor. Our plan was approved and funded, effective April 1, 1971.

Greene County, Va., is geographically north of Albemarle County and within a 50-mile radius of Charlottesville, Va. The total population of Greene County is approximately 5,400 of which 1,250 are school-age children and 350 are preschoolers, ages 3, 4, and 5. The school-age population is 88 percent white and 12 percent black. Out of these 1,600 children it was estimated by the county's department of social services, that 975 would be eligible for dental care based on our financing eligibility guidelines. The population of the county is stable, showing very little growth over the past 25 years. In 1970 there were 125 families on public assistance in the county and 250 families were eligible for surplus food from the U.S. Government.

Greene County is basically a rural community and the median income was $2,925 per family in 1970. This falls well below that of the State of Virginia, which had a median income of $4,964. There is no industry or major source of income for this community. Most of the working people commute to Charlottesville. There are some farmers but most of the farms are small. The men in the county that work commute to Charlottesville, or work on short contract agreements as carpenters, painters, repairmen, et cetera. Women who work do daywork in Charlottesville.

In the late 1960's and early 1970's, the availability of health care services in the county was minimal. The State health department was represented by a physician who was the local health department officer. His responsibilities included a four-county area and he contributed only half a day every 2 weeks to Greene County health activities. There were no local dental facilities and no public health dentists or private practicing dentists in the county. Those who sought dental treatment commuted 30 to 50 miles. There was one private practicing physician in the county, but he was obviously overworked and could not treat all the families there.

I might add that he is now 75 years of age.

To determine the need for dental treatment for school-age children in Greene County, random surveys were conducted in 1968 and 1969 at various schools and the examinations were done by licensed dentists. The object of the dental evaluation was to determine the following: (1) The condition of the soft tissue, (2) the presence of dental caries as to whether there was none, decay was obvious, or decay was gross, (3) whether or not the patient had had previous dental treatment, (4) to make a tentative orthodontic evaluation.

In a survey of 75 schoolchildren at one elementary school grades one through six, it was found that only 9 children had ever sought dental care, or 88 percent had never seen a dentist. Of these nine children three had sought emergency dental treatment only. Therefore, of the 75 children examined, only 6 had received restorative dental treatment. Of the remaining children, 42 had gross dental decay and all but 3 had obvious decay. A second survey was conducted on 79 first grade students at another school. Of the 79, 60 were found to have gross dental caries. Only six were found to be free or have minimal caries in the mouth. Of the 79 first grade students examined, 64 had never been seen by a dentist. Six had been seen by a dentist for emergency treatment or extractions only. Only eight had been seen by private dentists for restorative dental treatment. Therefore, of these 79 first grade students, 81 percent had never seen a dentist and 92 percent were in need of dental treatment.

A third survey was conducted on 57 fourth and fifth grade students at still another school. Of the 57 fourth and fifth graders, 32 were found to have gross dental caries and 21 were found to have obvious dental caries. Only four students were found to have no or minimal caries in the mouth. Therefore, 92.9 percent of the fourth and fifth graders examined needed restorative dental work.

Of the 57 students, 43 had never been seen by a dentist, 13 had been seen by a private dentist and 1 seen by a public health clinic. Of the 13 students seen by a private dentist, only 3 had no or minimal decay. The remaining 10 students exhibited obvious or gross dental caries and the condition of the mouth indicated that they had not been seen by a private dentist recently.

The fourth or fifth grade students were also evaluated for possible orthodontic treatment. Fifty-one percent of these children exhibited orthodontic problems requiring treatment. These children were not diagnosed tentatively in need of orthodontic treatment, but had definitive orthodontic problems such as cross bites, severe overjuts, deep overbite, overbite, et cetera.

In addition, 12 other students were tentative orthodontic patients and were in need of a space analysis. Of all the students in Greene County examined, including the students of the three schools just mentioned, 96 percent had inflamed oral tissues. The conditions of the soft tissue ranged from simple gingivitis to beginning periodontitis. Many of the students had fistulous tracts and had complaints of toothache. The principals and teachers in the different schools confirmed the fact that many student absences were a result of chronic toothaches.

There was no indication in any of the students examined that any form of preventive dental care was being practiced and good oral hygiene was neither emphasized nor taught either in the home or in the school. The principals and teachers were most receptive to the idea of initiating a dental health education program in the different classes.

These surveys taken in the late 1960's would be indicative of the dental disease problem of children in many areas where dental care has not been accessible or available for any number of reasons, not the least of which is inability to pay the high cost of good dental care.

In our planning we wanted to set up a comprehensive dental program in the specified area where we would have control over as many variables as possible in order to secure valid data for studies in effectiveness, cost/benefits, and the optimal age at which to begin an incremental care program. Baseline data was secured during the initiation of the program in 1971.

To date all eligible children except those whose parents or themselves have expressed no desire to participate in the program—less than 2 percent—are being examined annually and over 900 are in dental health maintenance. A child in dental health maintenance is defined as one who has had all dental treatment completed and has been placed on annual recall basis. School absences due to toothaches and dental emergency treatments have dropped off to negligible numbers. Therefore, we feel the program in 4 years to have been quite effective.

Cost/benefit analysis on a quarterly basis has revealed that during three out of four quarters the benefits have outweighed the costs. Benefit dollar values are based on the cost of dental services in private practices in the Charlottesville area.

We began our incremental program by treating 3-year olds, 6-year olds, and 12-year olds. We will be unable to arrive at an optimal age for initiation of an incremental care program for several more years, or until the original 3-year olds are 15. It is too early to even hazard a guess at this point as to what the optimal age will be, but we do feel that treatment of preschool children is important because by the time children enter school, 90 to 95 percent are in need of dental attention. The average child on entering school has three decayed teeth.

As mentioned earlier, the project was funded in April 1971. The first patients were seen in August of that year. In other words, it took us 4 months to gear up. A building was rented, equipment purchased and installed, staff procured and trained, eligibility requirements set, a transportation system devised, and record and reporting systems established.

And truly comprehensive dental care program will have a strong component of dental health education that includes a major emphasis on prevention. This has been accomplished in Greene County by working closely with the public school system. Our dental hygienist spends considerable time working in the schools, both in the classrooms and in inservice programs for teachers. Proper oral hygiene techniques, good eating habits, and the importance of periodic dental examinations and corrective dental care are stressed.

School-age children are picked up at school and taken to the clinic. Preschoolers are brought from their homes in the absence of other transportation.

School cooperation and the transportation system have been largely responsible for our low-broken appointment rate. Less than 4 percent of all dental appointments are broken. We have had two quarters during which there were no broken appointments.

We are now delivering dental care for over 900 children for $95,000 per year, plus some local assistance. The county pays the rent on the clinic facility and the local health and social services departments provide some inkind assistance, largely in the areas of case finding, eligibility establishment, and registration. For this outlay the children of the county are receiving in the neighborhood of $115,000 worth of dental care each year.

We feel we have shown that a public program in children's dental health can provide a high quality service in an effective manner and at reasonable cost.

On the basis of my experience, I would recommend that dental benefits be included as part of any national health insurance program for our country. Dental care is essential in total health care. Any meaningful effort to solve the dental health problems of our Nation must concentrate a major share of attention, and of resources, on the dental health of children. Dental disease, which usually begins in childhood, can also be most successfully and economically treated and prevented in these formative years. The child who receives adequate dental health protection will have a better chance of maintaining high standards of dental health and total health throughout his adult years. Because of the cost involved, some priorities will have to be set and for that reason, I strongly recommend that we begin with comprehensive dental care for preschool and school-age children on up to a certain age—possibly 12. This can be built on incrementally during succeeding years.

Also, it is my belief that any national program in children's dental health should be in association with the already established public school systems. I think this is a rational approach because school-age children are gathered together each day at central locations, and dental disease for the most part would be a preventable malady if dental health education, as a joint endeavor of dentistry and public education, was properly presented, understood, and practiced.

I thank you.

Mr. ROSTENKOWSKI. Thank you, Doctor.

It is at this point, gentlemen, that we open our hearing for a free interchange. I would like to encourage your discussion, principally because you are writing a record that will be ultimately used by the committee in executive session when we write this legislation.

I know that we had interruptions, but those are unavoidable. If there is any statement that any doctor has made that another disagree with, or if any of you would like to expound on the positions you have taken, we certainly encourage that.

In about 15 minutes we will join the discussion, with you, asking questions that we think should be answered, so that we can help those members who were not available for your testimony today.

Does anyone have questions of the others?

Dr. Kunkel?

Dr. Kunkel. I would like to make a comment. It is not really a question directed to anyone.

It has been amazing to me to hear the parallel comments going down this table, and the basic idea that has been presented that prevention is the key. It should not really surprise me, but I am happy to see it so well reinforced all the way down.

The other observation that I would make is that education has been mentioned repeatedly. Dental health education for the recipients of the care is a vital portion of the national health insurance proposal. I could not agree more with this comment. I think it would be interesting to note that at this point the American Dental Association has pursued legislation with this particular end as a separate, free-standing program, the Children's Dental Health Act which has been passed as a portion of a bill now in the Senate.

We feel very strongly that education is vital in discussing dental care in a national health insurance program.

Mr. Rostenkowski. Dr. Friedman?

Dr. Friedman. I would like to ask Dr. Kunkel what the position of the American Dental Association is specifically on a school-based care system. In my presentation, I tried to stress that part of prevention in dentistry is also the provision of care.

I know the official position of the ADA is to preserve or maintain the present dental care delivery system, and certainly I think all of us on the panel agree that the present dental system serves a function. But if we are going to propose or develop a pluralistic system, I would be interested to know why the American Dental Association does not support a direct care program within the school system where this would be a necessary adjunct to the other, more conventional delivery system.

Dr. Kunkel. I will answer that as best I can.

I think there are probably two areas of concern in this approach. First of all, I should restate our position on preservation of the existing structure. We are hopeful that we have a constructive alteration of the delivery system throughout the foreseeable future.

The process has been evolutionary, and we hope to maintain this. We are not particularly interested in revolution, and the idea of a free-standing, separate, possibly unsupervised dental auxiliary delivery program—that type of a care program is, to say the least, in our conception today a revolutionary idea in this country.

It may work nicely in the small countries in which it has been tried, but the two areas that concern us deeply are these. First is the initial cost. We are speaking of, I believe Dr. Friedman said 85,000 schools, and just roughly figuring at about $20,000 or so for the minimal equipping of those clinics, I think we would be placing about $1.5 billion to $2 billion as an initial cost before we have delivered any care at all.

That would be basically startup costs.

Then, the American Dental Association, which represents the vast majority of dentists in this country, is also very concerned about their accountability to the public in delivering the care.

We are granted licenses by the public through their legislatures in our various States. We are accountable therefore directly to the public for our activities.

Over the past recent years there has been an increasing interest in our continuing education programs so that we constantly upgrade our own abilities and our own ability to serve the public.

It seems incongruous to me that we would at the same time consider offering lesser trained persons to deliver care to children.

I am concerned that we would be establishing a second level of care, so to speak. I think these two areas are our major concerns.

Mr. Rostenkowski. Dr. Lobene?

Dr. Lobene. I feel compelled to respond to the last two areas concerning level of care. In the implementation of any program, expanded duty auxiliaries would work under the direct and immediate supervision of a licensed dentist in each of their communities. Under those circumstances, I don't see the fear of two levels of care as being realistic.

Second, there certainly exists in many jurisdictions within the States at the present time legislation which limits the number of auxiliaries, such as we suggested in our report.

A limitation exists on physicians' assistants in Massachusetts, and a physician is governed by a Practice Act that limits the use of these personnel to two per licensed physician. Certainly this would be one way to control and prevent the development of a system which would be second in any respect.

Mr. Rostenkowski. Dr. Friedman, what are the total costs of education of dentists and dental hygienists? Is there any estimate on what percentage of a dentist's work load can be performed by a hygienist?

Dr. Friedman. Dr. Lobene pointed out that 80 percent of what the dentist does can be performed by an additionally trained hygienist, what we call a therapist. Those are different terms for them.

As to the total costs, I would defer perhaps, to Dr. Terkla.

Mr. Rostenkowski. Dr. Terkla?

Dr. Terkla. According to the recent Institute of Michigan cost study, the range of costs to educate a dental student per year are between $6,000 and $16,000, depending upon the institution. The average cost for academic year 1972–73 was approximately $9,000.

I don't know whether I have available the costs for the dental hygienist or not.

Mr. Rostenkowski. Dr. Lobene?

Dr. Lobene. Since Forsyth operates a school in the private sector, our total cost per academic year of the 2-year program is $2,700 per year. We determined in our study that to upgrade these individuals to the point of where they could perform the services which they did perform, which included their conventional services of prevention, prophylaxis and the additional services of preparing cavities under the direction of the dentist and at the direction of the dentist, including the administration of local anesthetics, that an additional 25 weeks of training cost $3,300 per student, which would place the cost of educating these professionals to work with and under the supervision of a dentist and extend the capacity of the dentist to deliver more care, at $7,700, approximately.

Dr. Terkla. I just received information that the average cost is between $3,000 and $4,000 per year for the education of a dental hygienist.

Mr. Rostenkowski. Dr. Friedman.

Dr. Friedman. If I could go back to something Dr. Kunkel said about costs, he referred to the cost of equipping a school clinic is something like $20,000.

In Saskatchewan, it was done using a schoolroom that was there, and adapting it for dental purposes, for about $5,000. I don't think that the specific cost is the key here, rather than what the cost would be amortized over a number of years. Initial costs always can be frightening to people. It is the amortized costs that are important, and which I think are very reasonable and modest amounts. As I stated, we think it is about $35.

INTRODUCTION OF ASSOCIATES

I would also like to refer to Dr. Kunkel's remark, because it is a very old remark. I hear it all the time. I have been hearing it my entire professional life. I really wish I was a revolutionary. I am a reformist, and many of the things we are doing in an attempt to reform the system would make it function better.

I am not sure, however, as we approach 1976 that we should shirk from our revolutionary heritage. If it takes a revolution to get the dental profession to move into the area of responsible care for children, then perhaps that is what we ought to have. What we are talking about, however, is reforming a system that presently serves part of the population, supplementing it, and getting its cooperation. It is time that we avoided such inflammatory terms as "revolution."

Thank you.

Dr. Kunkel. I didn't mean that you were revolutionary. If you feel comfortable wearing that, that is all right, but that is not my intention, honestly. I agree with you that reformation is an admirable term, and I think that if our profession is not in a constant state of reformation, we are not viable.

I have been in practice since 1953, and I am probably serving twice as many people as when I started. That is because of the people in my office, and advanced technology. Much of the equipment that I work with was simply not invented when I graduated; nor were current methods of application, materials that are available, and certainly alterations in the functions of the people who work with me.

I think that we are really not at odds on the idea of a utilization of people to do additional things. We are just simply discussing a time frame, and inevitably when we discuss time frames there are going to be variations in the opinions of the various people. I would be astonished to find that the American dentist generally did not over the long period of time support changes in the use of auxiliary personnel, because this has been their history.

They have done it basically in response to demands.

Now, I would like to make a comment that Dr. Lobene brought up on demands and needs. I think sometimes there is confusion on this. Certainly if we statistically evaluate the dental needs of the country we can come up with frightening figures. When we come up with demand, this is quite a different thing, and demand depends on many factors.

Certainly one is the presence of a dental problem, but also involved is the dental education level of the person. How acutely aware are they of their needs?

When demands reach a certain level, it is at that point that things begin to happen, all of us simply being human. Hopefully, we can project far enough so that we can meet the dental demands of the American public, and this is what we have anticipated doing.

I believe that down the line the American Dental Association has stood for progressive changes.

Mr. ROSTENKOWSKI. Dr. Kunkel, does the ADA have any position on how the problems of delivering care to children might be overcome? I am speaking of the problems such as lack of transportation and apathetic parents. I understand the broken appointment rate in dental clinics for indigent children is as high as 45 to 47 percent.

Dr. KUNKEL. In which clinics? I didn't hear you?

Mr. ROSTENKOWSKI. In dental clinics for indigent children.

Dr. KUNKEL. I don't know what the figure of broken appointments is. I know there is a high incidence of broken appointments. Again, this probably goes back to the education problem we were speaking of: The fact that the dental demand of that patient isn't acute enough for the parent or the person themselves to get themselves in for the appointment. It apparently doesn't seem important enough to them. This falls in line with what was being said earlier about the school system providing an excellent means for dental health education.

I recognize that there also are transportation problems which should be addressed. A basic difficulty is that these problems vary greatly depending on location.

Mr. ROSTENKOWSKI. Dr. Williams?

Dr. WILLIAMS. Mr. Chairman, I agree there is a problem. I think solutions can be arrived at through effective outreach programs. I think you are familiar with the term "outreach," and I think that is one of the areas that needs to be addressed. It goes back, as previous speakers stated, to the educational aspect of it, and the lack of an effective outreach program.

Mr. ROSTENKOWSKI. Mr. Duncan will inquire.

Mr. DUNCAN. Thank you, Mr. Chairman.

I would like to thank the panel. You have been very helpful, and we appreciate your taking your time to come to help us on a subject that we think is of great importance to the American people.

What has been the experience in regard to utilization where the clinics offer completely free services? I assume there are clinics that offer free services in the country for dental care.

Would one of you care to respond?

Dr. FRIEDMAN. It depends in part on how you define a free clinic.

For example, some of our capitation programs serve relatively low-income people. These are blue collar workers and their families, Mexican-American families, people who have a relatively low education. They come to the dental group, or clinic, and we get maybe 80- or 90-percent utilization among these poor people who would not otherwise be getting dental care, and they don't pay anything for this service. It comes out of their fringe benefit employment.

The reason I use that example is that people will cite the case of the poor people's clinic and say that people don't come.

One reason they don't come is that they don't know the service exists. Second, they have transportation problems, and third, they don't have anybody to take care of the three or four kids who may be back at home. There are babysitting problems and transportation problems. So we know the utilization of some of these free clinics is not as high as we would want it to be.

Mr. DUNCAN. Is it as high as the fee-for-service clinics?

Dr. FRIEDMAN. We know if we view the country as a whole in that sense, that the utilization is only about 50 percent of the dental care facilities.

The utilization in any case, is too low, and we are trying to stimulate it by making people aware of their needs, and also trying to link up the service with the people. This is the biggest problem, to get the linkage or accessibility factor overcome.

Mr. DUNCAN. Dr. Kunkel, I reviewed the supplement you had with the statement that was in the New York Times in October.

In there, you indicate that service for the poor is paid for largely by HEW through the structure set up by the various States.

You indicate that we spend about $15 billion. That was in 1973, of course. The article states the States are not setting up exactly a proper structure on dental care to care for the poor. Would you mind elaborating on that a little further?

Dr. KUNKEL. You are referring to the medicaid program?

Mr. DUNCAN. Yes, sir.

Dr. KUNKEL. The dental portions of medicaid do vary tremendously from State to State, because of the matching fund structure of the law. Many States simply were unable to finance it.

As a result, they didn't implement sections of it, so there is a tremendous variation.

Mr. DUNCAN. We have some States where dental care is not covered under medicaid at all?

Dr. KUNKEL. Almost none of it. Other States have a variety of programs. I think perhaps Mr. Bishop could give you more explicit information on that.

Mr. BISHOP. There are three or four States, Mr. Chairman, which have a fairly extensive medicaid program. California is one. Massachusetts is one. New York for some time had one, but they have cut back. But overall, there is not a very extensive program for children's dental care under medicaid. At the time the law was passed, the association petitioned for dental care to be a required service at least for children under medicaid. That didn't happen. We now have some hope that the EPSDT section of medicaid will be implemented and under that there should be dental care in every State under the penalties that exist.

Mr. DUNCAN. Dr. Slaughter, in regard to your first point about existing discrimination against the physicians on the one hand and the rural surgeons and dentists on the other. Would your solution mean that extraction or filling of teeth should be covered by national health insurance?

Dr. SLAUGHTER. No, sir; Mr. Duncan. It is our position that the law clearly states what the covered services are, and we don't propose any expansion of those services, but simply the provision of those services at the choice of the patient by anyone who is licensed in that jurisdiction to provide those services.

So that where a dentist is licensed to provide services currently covered, they should be reimbursed for them.

Mr. DUNCAN. Would any of you care to comment on Dr. Lobene's statement about dental assistants, or paradental assistants?

I know many State laws actually prohibit the use of certain kinds of dental auxiliaries or assistants. Do you think that a program of national health insurance should override such legislation as we did in the HMO's?

Dr. KUNKEL. Mr. Duncan, of course, since the States dental practice acts do vary across the country, there have been different rules, you might say, promulgated for the use of auxiliaries. They range all the way from a rigid, rather laundry-list type of approach to what auxiliaries specifically are allowed to do to more open-eneded laws which allow auxiliaries to function within the discretion of the supervising dentist. It is difficult to generalize, as far as the country goes, as to what an expanded function auxiliary legally may or may not do.

I would hesitate to recommend, certainly, that the national health insurance program create an override of State dental practice acts. I think the States are in a far better position to assess their dental care needs.

Certainly, we would be opposed to a Federal override of the dental practice acts of the States.

Mr. DUNCAN. One other question, and I would like to ask perhaps Dr. Slaughter, who is an oral surgeon.

What about peer review in your own profession? Would you care to comment on that?

Dr. SLAUGHTER. Well, I am an oral surgeon, and as an oral surgeon I participate in the peer review mechanism of my local dental society, my State dental society, and, of course, my specialty.

The participation in peer review programs in dentistry is usual. However, oral surgeons, practicing as they do in hospitals, are members of credentials committees, and utilization and audit committees, and medical records committees. As such, the work of oral surgeons and the working knowledge of oral surgeons of the peer review mechanism is well established.

Dr. FRIEDMAN. I would suggest, sir, that the age range to consider would be the most practical.

If you are talking about a school-based program, we are talking about children essentially up through high school, because it is during that period that they are essentially not ambulatory. As they grow older, they will be able to take themselves to the private dentist.

Mr. Cotter. Dr. Friedman, would you start at the very early ages first?

Dr. Friedman. Yes. Not too early. If you start at the fourth-year level and not at the sixth, you are probably going to miss a very important element of the population. We feel if you start by age 6, you will catch many of the dental problems of the 4-year-olds in time to protect them.

Mr. Cotter. What kind of coverage would you provide, cosmetic as well as care?

Dr. Friedman. The basic problem with respect to children is just cavities.

Mr. Cotter. What about orthodontic work?

Dr. Friedman. We run into differences of opinion. When Dr. Deputy said 50 percent of the children he saw had orthodontic problems, I would question whether those problems were of such severity that they needed treatment. We define that as malpositioning of the teeth.

Mr. Cotter. What has to be done to correct the malocclusion as opposed to purely cosmetic?

Dr. Friedman. It is a matter of decision.

Mr. Cotter. This is a very expensive procedure.

Dr. Friedman. The one best qualified to make that is not necessarily the orthodontist, who is trained to see what he wants to see, as I see what I want to see. It might be a social worker who could assist in making the decision.

Mr. Cotter. What procedures would you require?

Dr. Friedman. I would recommend just fillings. That would be enough to take care of our energies.

Dr. Kunkel. Our recommendations are included in the material that we have given you, so I won't belabor it.

But the orthodontic problem is a difficult one. The way we have tried to handle it is to deal with crippling malocclusions, which are really debilitating ones, and not esthetic problems, necessarily, although they may well be that.

Mr. Cotter. But here you are in a judgment area.

Dr. Kunkel. That is true, it is a judgment area. I know of no way to keep it from being a judgmental area, but it is a severe problem to those crippled this way, and it should be definitely included in the program.

The other areas basically that we would be concerned about would be comprehensive services. This is a matter of preventive services, diagnostic services, and restorative services. Surgical services are sometimes necessary at that age. But it would be a comprehensive program. We feel that rather than dilute the comprehensive benefits of the program, if we are faced with dollar problems, we should lower the age groups of people covered, and cover them well.

Mr. Cotter. Thank you.

Dr. Lobene, I have a question. You are talking about the ability under various State laws for hygienists to perform expanded duties. What do you have in mind? What would these expanded duties be in terms that I can understand?

Dr. Lobene. Well, part of that has already been covered and I will try to be brief.

Generally speaking, the hygienist per se has traditionally been involved in laying on of the hands procedures which dealt with dental prophylaxis, which meant removing deposits and stains which accumulate on the expanded surfaces of the teeth; that is, those surfaces generally above the gum line.

As preventative methods have been evolved, they have been given the responsibility for applying topical medications in most jurisdictions.

These traditional duties as well as the expanded functions are as varied as the 50 States of the Union at the present time.

I can speak for the Commonwealth of Massachusetts. We recently were presented with a list of expanded functions. In reviewing what was labeled by our examiners as expanded functions, the Forsyth School had been teaching some of these expanded functions since we became a school in 1917. They certainly were not expanded functions, and they were not considered outside of the existing practice act.

The regulation of dentistry as I see it, and have analyzed it over the years in various jurisdictions, is by a practice act, and then the various boards empowered to issue rules and regulations which have the full power of law as to what may or may not be done.

Many of these have been promulgated as either positive listings or negative listings. Theoretically, my interpretation of this is, if you have a positive listing, that is what they may do. If there is no negative listing, that is a gray area. If there is a negative listing, these are things they may not do, and otherwise, you again find yourself in a gray area.

But generally speaking, the kinds of skills which we gave our advanced function hygienists included the injection of local anesthetics which is not allowed in most jurisdictions.

You may know that in the State of Washington this is presently legal, and I think up until a few weeks ago it was also legal in Pennsylvania. That would be clearly an expanded function from my viewpoint.

The actual cutting of hard and soft tissue is an expanded function, one that we taught our auxiliaries. There are several other experimental programs around the country that have worked with the cutting of soft tissues, and these are clearly expanded functions because these are——

Mr. Cotter. Peridontal work is this?

Dr. Lobene. Yes, such as cutting away of diseased tissue, gingivectomies, and so forth.

These are not reversible procedures and in all jurisdictions that I am aware of within the United States, they have been reserved exclusively for the licensed dentist.

Mr. Cotter. How about drilling of teeth?

Dr. Lobene. In exactly the same way. It has not, to the best of my knowledge, been legal for any paradental personnel to engage in the drilling of teeth in any of the States.

Mr. Cotter. It appears from here, and from everything that I have been told and learned about, that the administering of anesthesia is a very skilled science. I mean you need vast training. You can have serious malpractice problems in connections with it. I have had peridontal work done, and I tell you, I would want nothing but a very highly trained professional to perform anesthesia.

Dr. LOBENE. I am a peridontist, and I am boarded in my specialty and there are different degrees of involvement in the severity of peridontal disease, depending on when it is intercepted, and certainly early problems have been treated in two completed studies in this country, done within duly accredited dental schools. These have indicated that in fact parapersonnel, particularly the hygienists, working under the direct and immediate supervision of the dentist or the peridontist as the case may be, can perform these functions and can perform them quite adequately.

I would simply take this opportunity to reiterate that our experience with over 19,000 injections of local anesthetic during our research project demonstrated this was done very safely.

Mr. COTTER. Don't you have the fear of a malpractice suit with the attitude of people today? It seems that the cost of providing insurance for people without a high degree of training and schooling would be exorbitant if available.

Dr. LOBENE. Based upon what these personnel were required to know and what they needed to know and with the dentist, who has all of the knowledge, constantly present, malpractice should not be a problem. The dentist actually prescribed what the anesthetic for the day was to be, the concentration and the type of injection which was to be made.

Under those circumstances, I say again that I can only feel that this is a reasonably safe procedure to entrust to an appropriately trained auxiliary.

Mr. COTTER. Thank you very much.

Mr. VANIK [presiding]. I would like to ask some questions. Our consumer bulletins can help us learn how to save money, in those we tell people how to insulate their houses, and I think about how to get a proper dentist. I want to thank all of you for your very generous gift of time. I would hate to estimate the cost, what it means to you, but I like my dentist to be in no other business, because sometimes he might be working with me and thinking more seriously about the other enterprise in which he is involved.

I like to keep him out of the horse-raising business, or keep his wife out of the horse-raising business, because that sometimes means that I have to help buy the animals and to run the animal farm.

This fee-for-service thing is as difficult in dentistry as it is in the law. I had a little dental problem. I got one estimate of $2,200, and I got the job done for $46. I don't know whether it was a good job, or a bad job, but I have got my teeth.

I had the $46 job done over on the Eastern Shore, where my dentist lives and likes to fish. He has a good life. He doesn't worry about buying a Mercedes-Benz limousine and living it up.

If you need a lawyer, or a doctor, try to get a man who is not going through divorce, or else they are going to make you pay for it. They have a way of passing on the charges.

We all do it, but it makes the fee-for-service thing very, very difficult, and very unrational. You know, the sky can be the limit, or there is no limit to it, to what the charge is.

But that is an aside, and a bit of reflection on my own personal experience, and I shouldn't indulge the time of the committee in talking about it, excepting that I think we ought to give people some guidance on how to find a happy dentist or happy lawyer, or a doctor they are going to be comfortable with, because I think there are some very, very key quesions, some key things that could determine whether or not we are going to be satisfied and pleased, and properly charged for the services that are rendered.

I am very much impressed, Dr. Clark and Dr. Williams, with the idea of doing what we can in the schools. One of the things that worries me is the subject of periodontia, on which Dr. Lobene is an expert. Most of the periodontal doctors are working in the affluent areas, where there is a basic relationship between the need for periodontia and the money to pay for it.

I think most doctors here would concur with the fact that most periodontists operate in the affluent areas while the greatest need for service is in the central city areas, where this disease, this need, is far more critical.

Now, how can we handle this kind of problem and put this special kind of professional service where it is needed? Do any of you have any ideas on that point?

Yes, Dr. Clark?

Dr. Clark. I want to talk about the preventive aspect.

Mr. Vanik. Is there a doubt that the need is an innercity need?

Dr. Clark. The need for periodontal treatment is almost universal. In fact, most teeth are lost because of periodontal disease, beginning at the age of 25; whereas the greatest loss of teeth due to dental caries occurs before the age of 25. But realizing that there are not enough periodontists, though we wish we had them, in spite of this fact, what can we do?

This lack of professional resources intensifies my argument for school-based dental health education programs where a large segment of the population could be instructed in skills of prevention. The other side of the prevention coin relates to the need for universal fluoridation as a measure to reduce dental caries.

So in reference to your question, I promote very strongly the utilization of dental health education in schools, where this could at least be one stopgap measure in the progression of dental disease. It won't solve all the problems, but at least it will help.

Mr. Vanik. Tell me how your organization works. You are working in the schools?

Dr. Clark. My organization is the Metropolitan Health Planning Corp., a comprehensive health planning agency serving four counties in northeast Ohio. The corporation has received a grant for $1 million from the Ohio attorney general to administer a statewide dental health education program in Ohio schools. We are teaching core material and methodology to faculties in teacher colleges who, through inservice mechanisms, will teach classroom teachers. The classroom teachers, rather than dental professionals, will teach their pupils. But, of course, the teachers must be taught.

Mr. Vanik. That is what you are doing, training the teachers to make the rounds?

Dr. Clark. That is right, and we are training them in such a way that they will have clearly defined program objectives as to what they are to teach in each grade level, and establish measures to see if those objectives are reached.

Mr. Vanik. What would you do with more resources?

Dr. Clark. With additional resources, we would do more of the same thing. I feel that when people are under the stress of a dental office they are least receptive to concepts of prevention. Further, classroom teachers are better prepared to teach and have an opportunity, over a longer period of time, to install these concepts in their pupils.

I therefore feel that an ideal place where these things can be taught is in the classroom. Since we realize that only 40 percent of the population gets to the dentist, we do have a responsbility to the remaining 60 percent.

While I am talking, I would like to request that my entire prepared talk be added to the record.

Mr. Rostenkowski. It will be done.

Mr. Vanik. I have to give up my questioning, because I have to go vote. If there are comments, I will be happy to have them in the record.

Dr. Lobene. May I make a comment with respect to gum disease per se?

Mr. Rostenkowski [presiding]. Go ahead, doctor.

Dr. Lobene. Gingivitis, or a simple inflammation of the gums, which is a totally reversible lesion, if you will, is rampant among children, also, and I would like to amplify that that is a totally preventable entity. It is reversible. We should be giving this attention to children relative to the direct laying-on-of-the-hands care that would be necessary to execute this, and the hygienist is ideal presently, without any further expansion of duties, an ideally trained and educated paradental personnel to handle that particular lesion. It is preventable, and this is redundant, but I must repeat that the success of that particular approach depends upon the education of the individuals involved to perform daily oral hygiene in an effective manner—not simply the exercise, but in an effective manner.

That is a form of disease that could be conceivably totally eradicated.

Mr. Rostenkowski. Thank you, doctor.

Dr. Deputy, would the coverage of dental care services on a private practice fee-for-service basis solve the dental care problems of rural areas such as Greene County, Va.?

Dr. Deputy. Let me see if I have the question right. Would the fee-for-practice method——

Mr. Rostenkowski. Would it solve the dental problems in rural areas such as Greene County?

Dr. Deputy. I doubt it, because in Albermarle County, there are something like 40 dentists for 60,000 people, and yet when we went in there in the late 1950's we found 90 percent of the children had never been to a dentist. It may work in the future, if the public program gets started. It may work now, but certainly it hasn't been working over recent history, anyway.

Dr. Kunkel. Mr. Chairman, I might add along those lines that the American Dental Association has supported rather vigorously the National Health Service Corps program, which has not been utilized as broadly in the dental sector as it has in general medicine. Until this program is given a fair shot at working I think many of these areas are going to have difficulties.

Mr. Rostenkowski. This is a question thrown out for discussion and response by the panel generally.

Should national health insurance legislation put some penalty, monetary perhaps, on those communities which do not have fluoridation?

Dr. Clark?

Dr. Clark. I think they should be encouraged to do so.

Mr. Rostenkowski. Do you have any idea how?

Dr. Clark. If a State or a territory does not have fluoridation, I would reduce the percentage of money for treatment that went to that State. I would have a percentage fee scale, for those States proportionate to the degree of fluoridation to encourage them to fluoridate.

I don't think it would be appropriate to completely withhold treatment money if a State is not fluoridated.

I think that is a little far out.

Mr. Rostenkowski. What we are looking at, Doctor, is some incentive program. I was hoping I could get a discussion as to just how severe or how lightly we should treat this situation.

Dr. Kunkel?

Dr. Kunkel. I think the possibility lies in supporting the one-time installation cost of equipment rather than penalizing the community.

A portion of the Childrens' Dental Health Act is for startup costs for fluordination. This bill is pending before the House Committee on Interstate and Foreign Commerce and we are hopeful that it will be passed by Congress.

Mr. Rostenkowski. Dr. Kunkel, Los Angeles, I should think, is a pretty prosperous community. They haven't a program there.

When problems like this come up for legislative discussion we try to solve the problem. I was hoping you would provide us with guidance as to how the Government could help prevent decay.

Dr. Kunkel. We all have been involved in fluoridation battles in our careers, and we would welcome incentives from the Federal Government as proposed in the Children's Dental Health Act to which I just referred. We regret very much that the fluoridation referendum in Los Angeles was defeated by a vocal but uninformed minority of citizens.

Mr. Rostenkowski. Dr. Friedman?

Dr. Friedman. Coming from Los Angeles, I should be ashamed of the experience we have had there. It should be mentioned that a majority of the population did not vote against fluoridation. The problem is to get the people to turn out, because of a general apathy on some of these major issues.

I do have a problem with taking a punitive attitude toward this type of problem, and I don't think that is what you implied so much as a means of providing an incentive.

It is possible to provide incentives that would enable citizens to fluoridate. It should not be done, if possible, on a referendum basis. Many citizens have done it by legislative actions of the governments, the governing bodies.

We should certainly encourage this. We could say to the cities, that if the Government through national health insurance, if the Federal Government is to provide assistance for a school district program for its children, it certainly doesn't want to waste money by treating cavities that could be prevented much more directly through a general fluoridation process.

So I think it should be done on a promotional level, not to deprive people of what they presently have, but to offer them more in conjunction with the fluoridation of the water supply.

Dr. KUNKEL. It is possible, in considering a national health insurance program that variations in the deductibles or coinsurance might be used as incentives favoring fluoridated areas.

Mr. ROSTENKOWSKI. I want to thank you all. We certainly appreciate the time you have taken from your busy schedules to join us.

Thank you very much.

That will conclude the discussion with this panel.

Dr. Goldstein, Professor Ginsberg, Reverend Woelfl, and Dr. Barnes-McConnell.

A PANEL CONSISTING OF REV. PAUL A. WOELFL, S.J., CLEVELAND COMMITTEE FOR NATIONAL HEALTH INSURANCE; PATRICIA W. BARNES-McCONNELL, PH. D., MICHIGAN STATE UNIVERSITY; PROF. PAUL B. GINSBERG, MICHIGAN STATE UNIVERSITY; AND DR. ALLAN GOLDSTEIN, PUBLIC HEALTH ASSOCIATION OF NEW YORK CITY

Mr. ROSTENKOWSKI. Welcome to our hearings this afternoon. I am sure you know how the subcommittee operates. We give you an opportunity to make a statement, and then we like to see an interchange, a discussion among the panelists.

Father Woelfl, if you will.

STATEMENT OF REV. PAUL A. WOELFL, S.J.

Reverend WOELFL. Mr. Chairman, and members of the committee, my name is Fr. Paul Woelfl. I am a professor of political science at John Carroll University in Cleveland. I am here representing the Cleveland Committee for National Health Insurance, a coalition of labor, community action, and citizen organizations. I can say that I speak for a substantial number of people in the Cleveland area.

Mr. Chairman, I am very grateful for this opportunity to urge passage of the Health Security Act—H.R. 21—because it appears to the people I represent that this is the only proposal you have before you which makes sense and satisfies the needs.

People wonder how a government which was founded to "promote the general welfare" could have neglected for almost 200 years to see the necessary connection between good health and all the other blessings desired for the community—contentment, prosperity, peace, productivity, security, and just plain happiness. They have reasonably assume that a government forbidden to deprive them of "life, liberty, and property without due process" should be equally prepared to promote life, liberty, and property with due process. They base this assumption on the fact that life is not a privilege granted by government; and, therefore, neither is health. Both are natural endowments, or rights, which ought to be cherished, protected, and safeguarded by government. Neither life nor health have any value for the society unless they are relatively vigorous and satisfactorily productive.

Though I certainly do not mean to imply that the infirm and disabled contribute nothing to the overall good of the society, I do say that sickness, suffering, and disability, in their varying intensities, strain the capacity for the good life and diminish the potential for the common good.

Chronic illness has always been the most common cause of poverty, and sickness is the number one reason for absenteeism in the school and on the job. It is as difficult to call a sickly life a good life as it is to call a life of crime or a life of ignorance or a life of abject poverty a good life. None of them is life as it should be.

Yet, Mr. Chairman, it is rather disquieting to reflect how logically and realistically government has approached the maladies of crime and illiteracy and so on; and how illogically and, if I may say so, insensitively it has dealt with the more basic requirement of health.

It has never been dfficult to see that protection against crime and analogously protection against fire and various other calamities—cannot be placed on an open, competitive market for voluntary purchase at a price; for some would buy it, others would not. Some would settle for less protection than they need. Some would refuse to purchase police protection and the like. Therefore, the public has made police and fire protection available to all as a public service paid for in common, whether the individual ever has occasion to use them or not.

For similar reasons, governments—Federal, State, and local—have provided public roads and highways, public parks and libraries—all free of charge and supported at large. I might go on to remind you that there are many today who suggest that circumstances may be such as to require that rail and other forms of transportation may have to be supplied by government, because the private sector is no longer able to sustain the costs, provide the quality of services and evenly distribute the resources.

These were precisely the reasons which, in another day and in different contexts, justified the creation of a free, public school system. We are saying they are the reasons which, we maintain, justify the present demand for a national public, free health delivery system.

To standardize quality and costs, and to equitably distribute the burdens, a health program has to be nationwide for the same reasons that roads and currency have to be national.

Since only the National Government has the capacity to administer a uniform and coordinated program, the Federal Government must supply the machinery and the means.

Because of the peculiar nature of health and its problems—because some people need more than others, and because the element of choice is practically absent—since one can hardly decide to buy $6.89 worth of surgery because that is all he can afford—and because so accidental and unpredictable a thing as health should not introduce an arbitrary difference in the cost of life—there ought to be a way of removing the discriminating and inhibiting element; namely, the graduated fee-for service cost system which now dominates the system. We should treat health like taxes—as something we pay proportionate to our means, and whose benefits we share according to our needs and circumstances.

Not too many months ago, Mr. Chairman, the administration acknowledged the existence of a health delivery crisis. I suspect that you have been deluged with data to underscore that fact. I have no intention of adding to that volume. Nor do I think it is necessary. As health consumers, we all know from our own experience that we cannot afford to get sick beyond the limits of our insurance policies. But who can control that matter? We are all threatened by the unpredictables. We never know how much care we are going to need; how much it is going to cost us; how adequate our insurance will be when we need it; and how successful the professional service will be. No doctor or surgeon or no hospital can guarantee that the commodity we are buying will be delivered. We are paying for health and that too often is even beyond the control of the professional. People are entitled to peace of mind which comes from reasonable security. Today the price of such security purchasable through the private insurance system is far beyond the reach of all but the very wealthy who really do not need insurance. The poor, elderly, and worker fortunate enough to have a steady job gets partial coverage of his health needs through medicaid, medicare and group insurance; but they are not secure nor are they in any position to buy real security under the present system.

Moreover, since health is a lifetime condition, we need a delivery system which is more concerned with keeping us well than with merely curing our diseases. We want a system which we can use to the full extent when we need it, without fear of encumbering the other members of our family. We want a program that does not discriminate, exploit or dehumanize.

Mr. Chairman, I would think that these desires are generally shared by everyone. At the same time, I know that to have ideals is one thing and to accomplish them is something else. The question you have been wrestling with all too long is whether a full-scale national health program is feasible or not. I submit that, if health care is the right which I assume it is, and if good health is as essential to the Nation as you know it is, you have little choice. Sooner or later, whether piecemeal or otherwise, you must eventually come to a comprehensive, free, public, national health delivery system.

As I see it, there are three possible routes to follow. You can deal with health care as you have dealt with roads, police, fire and to a large extent education. You can preempt the business. Own and operate the facilities. Thoroughly socialize the system. This is the route that a number of countries have gone—some with more success than others. Most Americans, I suspect, would prefer not to go this radical route, if they can avoid it.

Or second, you can underwrite extensions of the present system; buy insurance for those who cannot afford it, subsidize private institutions; furnish incentives to the providers; and let it go at that. You have already done this with medicare and medicaid. Most of the proposals that you have before you are conceived along these lines. All of them can be criticized as being no real solution to the problem. They provide no cost controls, they leave millions unprovided for, they do little to improve quality, and they continue the burdens of deductibles, copayments, and limited benefits. We urge you not to give us more of this.

There is, however, still another route which could be described as a middleway, an approach which, on the one hand, avoids taking over all the providers; yet, on the other hand, coordinates them and regulates them so that they acquire a public character. There is a way of superimposing a governmental policy and a governmental superstructure on private enterprises without destroying them. The Federal Reserve System has done this; NASA has done this; and National Institutes of Health have done it. Almost all medical research is already supported and controlled by government. We would not get more or better research at lower costs by removing government from this area. The laboratories involved in these programs have not lost their private, competitive character.

H.R. 21 proposes to go this route; to make use of the already existing health delivery personnel and facilities; to encourage their ambitions and subsidize their efforts. It would create the machinery for coordinating the work of professionals, institutions, and industries. It would effectively eliminate wasted effort, duplication, and inefficiency. And at the same time, it would give everyone the best possible quality of care as one of their civil rights.

The crucial question of whether we can afford this program is, as others have noted, really a nonissue. We are already spending $104 billion or an average of $496 per person or $1,984 per family of four for health care. The trouble, of course, is that not everyone is paying that share and not everyone is getting the equivalent service.

Government is already the largest health care spender. It buys about 34 percent of all the health services at a market price which is inflated and which continues to escalate at an inordinate rate. Government's willingness to pay the providers their inflated prices affects the insurance rates and out-of-pocket costs of the consumer.

Mr. Chairman, the ordinary individual will pay what he has to pay to stay alive. He really has no choice. In a true sense, no amount of money value can be placed on health. Yet it does not make sense to purchase life or health at a cost of going so deeply in debt as to mortgage the future. And this happens all too often.

The public wants better health care at a price it can afford. If a national referendum could be held to assess its will, I am sure that the choice would be overwhelmingly in favor of H.R. 21. As representatives of the people it is your responsibility to consider their wishes and try to make them a reality.

Again, I am grateful for your attention and will try to answer any questions my comments may have prompted.

Mr. Cotter [presiding]. Thank you very much, Reverend Woelfl, for a very fine statement.

Dr. Barnes-McConnell, would you like to proceed?

STATEMENT OF PATRICIA W. BARNES-McCONNELL, PH. D.

Dr. Barnes-McConnell. Thank you for this opportunity. In the interest of time I will proceed as quickly as possible to the issues.

HISTORICAL CONTEXT

Without doubt, national health insurance has been a long time coming. Systematically, astute men and women have been developing a support system that would be necessary to insure the success of any national health insurance program. This step-by-step development has encouraged careful and deliberate programing resulting in an intricate system of checks and balances. The goal of this system, enunciated many times throughout the various enabling legislations, is quality care at reasonable costs for all the citizenry, especially those from grossly underserved groups. The support system has evolved to include the PSRO structure, utilization review procedures, health maintenance organizations and the broad new health planning and resources development structure. A major objective of all these elaborate structures is to contain the inevitable inflationary impact of a national health insurance program.

THE PROBLEM

All signs indicate that national health insurance will encourage people to use health care much more than they have in the past. Putting greater strain on the facilities and services available, this increased demand will put a heavy burden on those paying the bills. One way which has evolved to meet the demand and ease the strain on the facilities and the manpower is the prepaid group practices—HMO's. But as the Kaiser program has shown, with increasing use by prepaid members, the facility must see more patients in less time in order to remain solvent. This cattle chute approach is often made necessary by the facts of life, causing disgruntlement among the professional staff. The turnover among them, therefore, is great. The result promises not only care which is harried, agitated, and impatient, but care which is impersonal as any seen prior to national health insurance, only this time it will be built into the structure.

At another level, norms for care are to define the specific care behaviors to be expected of the medical teams. Obedience to these norms virtually guarantees protection from malpractice suits for participating medical personnel. The norms are set by the physician-dominated PSRO's using utilization review data to evaluate services and the quality of care. PSRO norms reflecting this concern for quality care can run head on into a clear responsibility for cost containment. In fact, cost containment and quality care can be and often are a contradiction in terms, a conflict which is not easily resolved. The present administration's response is to point to the consumer dominated health planning and resources development structure, saying they will be the ones to decide the level of care. It is true that health systems agencies are to determine what health facilities and services are needed in a community. They do not, however, have a say in PSRO norms for health care.

Theoretically, what we have at best, then, as we look toward national health insurance, is a constraining structure where the consumers define community needs and approve the provider responses to these needs. These provider responses are implemented within the constraints placed upon them by utilization review and PSRO's. The PSRO's, in a loose peer review system, are to try to hold the line on program costs through the designation of appropriate and necessary care procedures to be received by the consumers in these programs.

I trust that you do not need my evaluation of that tangled state of affairs. I must say, however, that it is obvious that moving toward national health insurance, the issues get more complex and greater vigilance will be required.

DIRECTIONS FOR THE FUTURE

First, both our previous orientation to health and our present structure have supported a curative approach to health care. That is, concern is not expressed for the health status of a population until that status is in jeopardy requiring expensive medical personnel, expensive medical facilities and equipment, and expensive, often long-term, pharmacological programs to attempt control of, if not cure of, offending conditions. Another approach which in no way suggests one should ignore the curative health needs of the population, might well be a health conservation approach. Such an approach understands that with a lack of concern for what leads to ill health, there is not enough money in the world, nor could there be enough curative health machines, manpower or facilities, to make a dent in our overall health status. While many of us encourage counterproductive behavior out of ignorance, more of us joyfully engage in self-destructive activity fully confident that, like the cavalry coming over the hill, the curative system will save us in the end. Through this illusion, we have sold ourselves a bill of goods.

Community health conservation would not only emphasize health education and preventive health measures, it would also emphasize community advocacy in the identification of community need which impinge on the health of a population and the identification of resources to address those needs. This may include: (1) involvement in local environmental or occupational health issues, such as local air and water pollution control boards; (2) investigation of and working to change unhealthy but culturally supported lifestyles, such as programs to help expectant mothers give up smoking; and (3) health related community development activities, such as programs to train community people for consumer participation on various governing boards, commissions, and councils. Commitment to such a notion means funding not only specific programs but research exploring the potential of health conservation as well. Further, and more importantly, it means including health conservation services under the reimbursement structure. While money isn't everything, experience has shown that the most professional effort is expended in those areas receiving Federal support. A national health insurance bill must give this new direction to the country.

Reimbursable health conservation services could well be the answer to increasing hospital costs which accrue from decreasing hospital utilization. Health education and community health advocacy through reimbursable expanded outreach efforts and expanded ambulatory care services would be a more realistic approach to improving the health status of the entire population in the face of escalating curative health costs.

A second concern for the future addresses another political situation. It seems that presently we are on a path headed back to the old States' rights position. Recent behavior of the President, his cabinet, HEW leaders, et cetera, make such a direction clear. If the Federal Government was a bit overzealous in its regulations of States' activities in the past, it was because of the great discrepancies among the States in providing services to the people, services for which all had received Federal aid. Any small gains must not be lost by the resignation of the keeper of the common trust and dispenser of the general fund. There should be no compromise on what are to be considered acceptable standards nor should there be any compromise on the national regulations defining approved, reimbursable health care.

In summary, I wish to reemphasize my position that the whole NHI superstructure, while important, cannot replace the good sense of the population. To have a fighting chance of improving the overall health status of this country at a cost we can afford, we must take a closer look at where we are going. Curative health procedures must, of course, be more equitably distributed. More important, however, is the need for Federal leadership in forming a new national direction. Federal leadership must demonstrate concern and support for overall health conservation with clear Federal guidelines to insure State compliance resulting in a true national health insurance program.

Thank you very much.

[An attachment to the statement follows:]

[From Detroit Free Press, Nov. 22, 1975]

HEALTH EDUCATORS GOING WHERE THE PEOPLE ARE

(By Dolores Katz)

See that guy in the corner of the pool hall? The one in the Coors beer hat who's talking in a low voice to the teenage boy?

He's a health educator from the county health department, and that suspicious-looking package he's passing to the boy contains rainbow-colored condoms.

See the barber who's carrying on an animated conversation with his customer while he cuts his hair? They're not discussing baseball scores. The customer is having family problems and the barber is telling him where to go for counseling.

The barber and the health department worker in the funny hat represent new attempts by health educators to get usable health information to the public.

They've decided that pamphlets distributed in doctor's offices and in clinics just don't do the job. The people who need the information most don't go to clinics or doctor's offices, don't read pamphlets, and are too intimidated by doctors in white coats to ask the questions they want answered.

So new health education programs are being designed that eschew clinics and pamphlets in favor of informal, friendly contacts between people in places that people are used to visiting: barber shops, work places, bars and pool halls.

Following are descriptions of a few of the most innovative approaches to health education. All of them were subjects of papers presented last week in Chicago at the annual meeting of the American Public Health Association.

Family planning. In October 1972, the South Carolina Department of Health decided to do something about the high rate of out-of-wedlock births in Dillon County. The problem was most acute among black teenagers aged 15 to 19.

Male teenagers were the most difficult group to reach; they seemed reluctant to use the health department clinic, which was staffed by women and usually crowded with female clients.

So the health department decided that if the clients wouldn't come to them, they would go to the clients.

Now, it is not unusual to see a health department worker roar up to a bar or pool hall at night or a factory during lunch hour with a black plastic bag full of health education pamphlets and condoms strapped to the back seat of his motorcycle.

The first time he talks to a client, he may not even mention contraception, but concentrate on establishing a friendly rapport. Later, he offers advice, information, and free condoms. The teenagers are never required to come to the health department clinic. If a blood sample is needed for venereal disease testing, it is taken on the spot and tested later at the lab.

The program is achieving its purpose. In the first three years of its operation, the rate of out-of-wedlock births among black teenagers in Dillon County has dropped by more than 10 percent.

Ten barbers in Rochester, N.Y., are dispensing advice on health problems along with their haircuts. The barbers are graduates of a program developed by the University of Rochester's community medicine department in an attempt to make use of the easy, confidential relationship that often develops between barbers and their clients.

Members of the Rochester barbers union were offered an eight-week course in health education that covered communication skills, hypertension, venereal disease, drugs, dermatology, alcohol, and family problems. Those who passed a test at the end of the course were given certificates and a notebook containing telephone numbers of local community agencies that they could use for referrals.

The program has worked so well that the university is planning to offer similar education programs to bartenders, beauticians, and hotel and motel employes.

Doctors at Arkansas Children's Hospital in Little Rock are using the familiar medium of television to educate parents and children in the pediatric clinic waiting room.

A cassette television monitor was set up in the waiting room to display an hour-long videotape that covered four basic areas of child health care: preventative measures, nutrition, infant handling and bathing, and immunizations. . . .

Parents and older children were interviewed before the video program began to test their knowledge about the subjects. They were tested again immediately after they saw the tape, and again two weeks later.

The tests showed that parents and their children knew substantially more than basic health principles after the program and that they had a much more positive attitude toward the clinic.

Mr. Rostenkowski [presiding]. Thank you.

Dr. Ginsberg?

STATEMENT OF PROF. PAUL B. GINSBERG

Dr. Ginsberg. Mr. Chairman, my name is Paul B. Ginsberg, and I am a member of the faculty of the Department of Economics and the Department of Community Medicine at Michigan State University.

My testimony is based upon research and analysis that I have done on this subject, and represents my personal views and not necessarily those of my employer.

Health insurance is purchased for two reasons. First, it provides protection against the financial consequences of ill health, and second, it allows advantage to be taken of a tax loophole—namely that employer-paid health insurance benefits are not taxable to either the employer or the employee. Thus, an employer-paid health insurance policy is a means of receiving tax-free income.

Putting aside the tax subsidy issue momentarily, these benefits of reduction of financial risks do not come costlessly. Like all forms of insurance, benefit payments are less than premiums because of administrative costs and profits. However, in health insurance, important additional costs are incurred. It is not practical for health insurance policies to pay off so many dollars for a heart attack, so much for cancer, and so much for influenza. Instead, benefits are paid on the basis of the use of medical care. Service benefits pay a proportion of the costs of care, while indemnity benefits pay a certain dollar amount for each service used.

Insurance benefits denominated in terms of the use of health service act to subsidize the use of those services. Thus, patients and their physicians are induced to take into account only a small portion of the true costs of medical services. This subsidy effect causes both an overutilization of health services, and inflation of the cost of a unit of medical care. There has been extensive empirical verification in scholarly literature of this major cost of health insurance—a cost that must be subtracted from the risk reduction benefits to determine its value.

While health insurance is a costly form of financial protection, it is purchased extensively by the nonpoor because (*a*) the inflation caused by health insurance is spread over all citizens, not just the ones in the experience rated group, and (*b*) the income tax system subsidizes its purchase. Thus, it is conceivable that the nonpoor may already be overinsured for medical services, and an ill-conceived national health insurance program may produce very little additional risk reduction for this group, but have severe inflationary effects and overburden the tax system. Indeed it has been estimated—M. S. Feldstein, Journal of Political Economy, March 1973—that the Nation already wastes $4 billion per year because of this excess health insurance.

In discussing the implications of this analysis for national health insurance. the needs of the poor and nonpoor must be considered separately. A subsidy or direct provision of health insurance for the poor is desirable, because we want to enable the poor to use more health services. It is likely that better access to health services will improve the health of the poor, and many nonpoor Americans are willing to subsidize such services to permit this. Since the medicaid program has some well-known deficiencies, a replacement for it should be a central part of any program of national health insurance.

When we turn to the vast majority of the population that is nonpoor, we no longer desire to induce them to use more health services. Studies show that changes in health services utilization have little effect on mortality and morbidity of the population as a whole. The benefits of marginal changes in health care resources are tiny compared to benefits from reduced smoking and drinking and improvements in the environment. Health insurance programs that encourage the nonpoor to use more services are likely to be very costly, accelerate inflation in health care costs, and accomplish very little in the way of health improvement.

There are a number of other factors that argue against comprehensive national health insurance benefits for the nonpoor. One is the fact that many of them already have health insurance benefits as comprehensive as those envisioned under many NHI proposals. Replacing private insurance with public insurance needlessly expands the public sector and burdens the tax system. Another problem is the difficulties in reimbursing providers of care under a system where all medical bills are paid by the Government. At a recent conference on regulatory reform, I advocated prospective reimbursement of hospitals. When the third parties are paying all of the bills, there is no alternative. However, this is an untested, unproved system of reimbursement, with difficult conceptual problems to be worked out. But, if a greater proportion of bills were paid directly by patients, hospitals would experience more market incentives for cost containment, and prospective reimbursement might not be necessary. Third-party reimbursement of physicians also has difficulties. A visit is not a homogenous service, as its quality—and physician time input—varies substantially across physicians, and over time—consider the medicaid mills. A fair and efficient reimbursement system is difficult under these circumstances.

While I counsel against comprehensive benefits for the nonpoor, I do believe that catastrophic benefits would be useful. For reasons that are not clear, private insurers have tended to place upper limits on benefits, often below the costs of treatment for a number of conditions. When catastrophic benefits are included, usually the premium cost is low, but the extra financial security for the policyholder is very high. Provision of such benefits under national health insurance would be desirable because of their high risk reduction at low cost. This could be accomplished by granting benefits to all who exceed a very large deductible, as in the Long-Ribicoff proposal, or by having income-related deductibles, as has been proposed by Prof. Martin Feldstein of Harvard University [The Public Interest, 1971]. Under Feldstein's proposal, deductibles would be very small, or zero for the poor, and increase with income. This would avoid the difficulty of a sharp change in benefits at an arbitrary definition of poverty. Also, many nonpoor might find it in their interest to self-insure any medical expenditures incurred before the deductible is exceeded, whereby the national health insurance would take over. However, the tax subsidy to the purchase of health insurance would work against this.

There are a number of recommendations that I would like to make which are relevant to both the type of national health insurance I have outlined and to more comprehensive plans. First, it may be inadvisable to insure expenditures for ambulatory services as well as those for inpatient hospital services. The argument behind balanced coverage is that there currently exists an incentive to hospitalize individuals for diagnostic workups so that the cost of these tests is covered by insurance. However, empirical research has not supported this notion. Econometric work by Newhouse and Phelps [National Bureau of Economic Research, Conference on the Role of Health Insurance in the Health Services Sector, 1974] shows that when insurance for outpatient services increases, hospital use goes up. Also, a case study by Lewis and Kearnes [New England Journal of Medicine, 1970] showed that extension of insurance benefits to physician services in groups with hospital insurance increased use of the hospital.

While the argument for coverage of physician services does not stand up, there are strong arguments against this. Expenditures for physician services are reasonably predictable, and insuring them accomplishes little in the way of risk reduction. On the other hand, empirical work has shown outpatient services to be most sensitive to the subsidy effect of health insurance. Consequently, the cost-benefit ratio for this type of insurance is particularly poor.

A final reason is that the health care system will not be able to tolerate extensive coverage of ambulatory services in the short run. Newhouse, Phelps, and Schwartz in the New England Journal of Medicine [June 13, 1974] have estimated that a full-coverage national health insurance plan would increase demand for ambulatory services by 75 percent. An increase of a much smaller magnitude would result in both extensive queues and inflation.

A second suggestion is the use of indemnity instead of service benefits. Recently published research of my own [Economic Inquiry, March 1975] demonstrates that indemnity benefits have less of an inflationary tendency than service benefits. Intuitively, this occurs because indemnity benefits do not dilute the consumer's incentive to be cost conscious to as great an extent as service benefits do.

A third suggestion is to eliminate the tax subsidy to the purchase of health insurance. The overuse of health insurance to cover routine medical expenses is costly to our Nation in causing us to devote too many resources to health care. In addition, the benefits of this loophole are larger to higher income people. While it may have been useful in the past, it is counterproductive today.

Mr. ROSTENKOWSKI. Thank you, Dr. Ginsberg.

Dr. Goldstein?

STATEMENT OF ALLAN B. GOLDSTEIN, M.D.

Dr. GOLDSTEIN. My name is Allan Goldstein. It is my pleasure to testify on behalf of the Public Health Association of New York City, a nonprofit organization of public health professionals dedicated to the improvement of health care delivery in New York City, and the Nation. I have submitted a more extensive statement for the record.

Mr. ROSTENKOWSKI. It has been included in the record.

Dr. GOLDSTEIN. The organization is composed of 850 members. On ther behalf I testify.

We firmly believe that any national health insurance program which alters the mechanism for financing the Nation's health care without altering the health care delivery system will have failed from the outset. The emphasis of the legislative proposals to date is on financing mechanism for medical services rather than the restructuring of the system within which health services are delivered. As we have learned from medicare and medicaid, improved medical care does not automatically derive from the infusion of additional funds into the system. Therefore, these hearings should more appropriately be addressed to the characteristics of the existing health care system, and the nature and direction of desirable change within that system. Of particular concern to this committee is the promulgation of legislation that shall assure services to all, that are of high quality and efficiently delivered; permit experimentation with new modalities of health care organization, delivery, and financing; and insure sufficient flexibility to adapt to changing circumstances. These goals can be achieved if the legislation addresses itself to those characteristics and criteria which are requisite to such a system, rather than mandating specific structural models.

A basic assumption is that insurance must be universal and must cover preventive and primary care as well as inpatient care. It is essential that there be no copayment for primary care. Within this context, I shall discuss four areas which any health system legislation should address: (1) Regulation and monitoring. (2) Experimentation in organizing and delivering service. (3) Reimbursement for services. (4) Citizen involvement.

The concluding remarks will address the impact such legislation would have on the provision of services in New York, with special consideration of the current fiscal crisis in that city.

REGULATION AND MONITORING

No legislation should be passed without adequate regulatory procedures to assure both quality of care and control of costs. Included in this must be sufficient appropriations to fulfill the regulatory mandate. Any regulatory system should be operational prior to the implementation of financing or service programs.

QUALITY OF CARE

Quality of care is one of two essential regulatory areas. Utilization review, currently mandated for PSRO's should be extended to ambulatory as well as inpatient services. In addition to this peer review mechanism, there must be an external auditor of services rendered which takes into consideration the consumer's perspective. This monitoring system must provide feedback to both the provider and the consumer.

Not only should services be subject to closer scrutiny, but institutional and private providers should be more effectively monitored. There are currently a multiplicity of agencies and organizations which accredit hospitals and other institutional facilities. This function should be consolidated within a single agency. Similarly, there is no rationale for lifetime licensure of health professionals. Periodic relicensure would require all health care professionals, not just physicians and nurses, to maintain reasonable levels of expertise in their fields thereby providing some assurance of high quality care.

COST CONTAINMENT

Cost control is the second requisite component of the regulatory process. First, and most globally, cost control means minimizing the cost to society of medical care services and of disability due to illness. While most of us are conscious of the expenditure for services, the loss of productivity and the anguish resulting from illness are often forgotten in assessing costs. This is especially true of occupational and environmental disease. In this regard, Public Health Association of New York City is particularly pleased by the attention given to this area in the National Health Planning and Resources Development Act of 1974.

Cost control means the elimination of duplicative and underutilized services. One way of assessing the extent of these problems is the development and institution of a single, uniform statistical reporting and cost accounting system as part of any national health insurance system. Second, a system of monitoring and site visits should be instituted.

Finally, cost control means consideration of the human element. It is unrealistic to expect the individual provider, be it a medical center or a private practitioner, to be constantly cognizant of the societal implications of his actions.

Consequently, the regulator must maintain the appropriate perspective, educate the providers of care, and establish incentives for efficiency and appropriateness of care.

EXPERIMENTATION IN ORGANIZING AND DELIVERING SERVICE

American society has favored a pluralistic system of medical care based almost entirely on the ability of the patient to pay. Rather than utilizing primary care practitioners, the affluent have chosen to receive medical services from specialists with admitting privileges at medical centers. Members of the working middle class have had access to prepaid group practices such as Kaiser Permanente, Puget Sound, and HIP. Yet, the prepaid practice HMO model has not caught on because even the upper middle class has been unable to afford the premiums—particularly because of the generous mandated HMO benefits. This model has not solved the needs of the urban environment. What has mushroomed in the cities has been hospital-based ambulatory care programs, too often skewed toward emergency room medical care. In addition, shared health facilities or clinics treating predominantly medicaid patients have brought physicians to the low-income areas of the city. However, these facilities have resulted in further abuse of patient care, and have contributed to the problem, rather than the solution.

While a national health care financing bill should allow experimentation in the organization and delivery of care, adequate mechanisms must be established to analyze the various organizational structures utilized so that we may begin to evaluate their outcomes and determine which delivery systems should be encouraged or discouraged. Pluralism in delivery systems should not be extolled for its own sake.

REIMBURSEMENT FOR SERVICES

A national health care program must be publicly administered and accountable to both those who finance and use the services. It cannot be administered by a fiscal intermediary.

Total public financing of health care calls for total public accountability. Government must assume a direct role in financing and not relegate this responsibility to a third party carrier. The Government should control the financing and delivery of services as well as monitoring the quality of care. The use of fiscal intermediaries will diffuse the regulatory mechanism and insulate the provider from accountability.

The manner in which Government pays the provider must be flexible owing to the present pluralistic health care delivery system. Experimentation using at least the fee for service and capitation methods must be encouraged. Certain health providers may wish to provide a total package of care for their patients and be reimbursed on a capitation basis, while others may continue to experiment with a fee-for-service mechanism. Under either system, emphasis must be placed on ambulatory care. The reimbursement formula must take into account age, sex, income levels of the population served.

CITIZEN DEVELOPMENT

To guarantee flexibility and change, those who provide services must have an ongoing dialog with those who receive them. The consumer must be able to articulate his problems in a manner such that providers will react and implement changes in the system. A proportion of the governing body of any health care system should be composed of those receiving services. A role of the consumer is to monitor services provided to assure patient amenities. Consumers and providers must work together toward a restructuring of our present delivery system. A coalition of consumers and providers can catalyze legislative change.

IMPACT ON NEW YORK CITY

Nationally, we have seen an increasing interest and concern with the costs of medical care. The National Health Planning and Resources Development Act of 1974 emphasizes cost containment and accountability among its purposes and priorities. In New York City, the current municipal fiscal crisis has required us to focus on the interaction of money and services so that we can improve the cost effectiveness of the system. I shall highlight the impact of budgetary cutbacks on health care services provided in New York and indicate how this scenario would differ if the regulatory mechanisms we proposed were currently operations.

The city of New York expends health care funds for medicaid payments, subsidization of the Health and Hospitals Corp., medical benefit premiums for its employees preventive services, and a myriad of categorical programs. The fiscal crisis has impacted on health services by:

(1) A mandated freeze on medicaid expenditures by the State. One proposed solution is freezing reimbursement rates without freezing associated costs of services rendered. (2) Decreased subsidies to the Health and Hospitals Corp. resulting in both across-the-board and categorical program cuts. (3) Decreased availability of preventive services. (4) Cuts in categorical programs particularly ghetto medicine which subsidizes voluntary hospitals for services provided to the medically indigent.

All sectors of the medical care system and the entire populace of New York City have felt or will feel the effects of these cuts.

If a financing mechanism for health care services were operational, health would be relatively insulated from the ravages of the budgetary crisis. Patients would not have to wait 17 weeks for a clinic appointment. Elective surgical procedures would not have to be postponed indefinitely. Poor patients would not have to be turned away from voluntary hospitals because of an inability to pay.

The net effort of a combined regulatory and financing mechanism might result in a reduction in the societal costs of services, the delivery of more primary care services, and insulate the health care delivery system from local fiscal problems. These are highly desirable goals.

If, for a moment, we invert our theoretical model, and ask the question, how would regulatory and financial mechanisms have impacted upon the city's fiscal crisis. By decreasing the total cost of services and by redistributing the financial costs of underwriting these services, the burden on the municipal government would be significantly decreased.

On behalf of the Public Health Association of New York City, let me thank you for your time and attention.

I thank you for your time.

[The prepared statement follows:]

STATEMENT OF ALLAN B. GOLDSTEIN, M.D., MEMBER, PUBLIC HEALTH ASSOCIATION OF NEW YORK CITY

My name is Allan Goldstein, member of the Public Health Association of New York City, a non-profit organization of public health professionals dedicated to the improvement of health care delivery in New York City and the nation. The organization is composed of 850 members. On their behalf I testify.

We firmly believe that any national health insurance program which alters the mechanism for financing the nation's health care without altering the health care delivery system will have failed from the outset. The emphasis of the legislative proposals to date is on financing mechanism for medical services rather than the restructuring of the system within which health services are delivered. As we have learned from Medicare and Medicaid, improved medical care does not automatically derive from the infusion of additional funds into the system. Therefore, these hearings should more appropriately be addressed to the characteristics of the existing health care system, and the nature and direction of desirable change within that system.

Of particular concern to this Committee is the promulgation of legislation that shall assure services to all, that are of high quality and efficiently delivered; permit experimentation with new modalities of health care organization, delivery and financing; and insure sufficient flexibility to adapt to changing circumstances. These goals can be acheved if the legislation addresses itself to those characteristics and criteria which are requisite to such a system, rather than mandating specific structural models. A basic assumption is that insurance must be universal and cover preventive and primary care as well as inpatient care. It is essential that there bo no copayment for primary care. Within this context, I shall discuss four areas which any health system legislation must address:

1. Regulation and monitoring.
2. Experimentation in organizing and delivery service.
3. Reimbursement for services.
4. Citizen involvement.

The concluding remarks will address the impact such legislation would have on the provision of services in New York, with special consideration of the current fiscal crisis.

REGULATION AND MONITORING

No legislation should be passed without adequate regulatory procedures to assure both quality of care and control of costs. Included in this must be sufficient appropriations to fulfill the regulatory mandate. Any regulatory system should be operational prior to the implementation of financing or service programs.

Quality of care

Quality of care is one of two essential regulatory areas. Utilization review, currently mandated for PSRO's should be extended to ambulatory as well as inpatient services. In addition to this peer review mechanism, there must be an external auditor of services rendered which takes into consideration the consumers' perspective. This monitoring system must provide feedback to both the provider and the consumer.

Not only should services be subject to closer scrutiny, but institutional and private providers should be more effectively monitored. There are currently a multiplicity of agencies and organizations which accredit hospitals and other institutional facilities. This function should be consolidated within a single agency. Similarly, there is no rationale for lifetime licensure of health professionals. Periodic relicensure would require all health care professionals, not just physicians and nurses, to maintain reasonable levels of expertise in their fields thereby providing some assurance of high quality care.

Cost containment

Cost control is the second requisite component of the regulatory process. First, and most broadly, cost control means minimizing the cost to society of medical care services and of disability due to illness. While most of us are conscious of the expenditure for services, the loss of productivity and the anguish resulting from illness are often forgotten in assessing costs. This is especially true of occupational and environmental disease. In this regard, P.H.A.N.Y.C. is particularly pleased by the attention given to this area in the National Health Planning and Resources Development Act of 1974.

Cost control also means promoting, utilizing and providing incentives for the provision of care in the most economically efficient manner. For example, ambulatory or day surgery can provide services more economically than a hospital. Yet the forces impinging on the system mitigate against the most cost efficient modality. Blue Cross is reluctant to cover any ambulatory services, even surgery, because a fiscal loss could occur through increased demand for ambulatory surgery and continued use of inpatient facilities. The hospital administrator prefers inpatient procedures as the hospitals' revenues depend upon bed utilization. All other things being equal, the physician will elect the alternative that is more lucrative to him rather than less costly to the system. And, alas, the patient has little or no choice.

Cost control means the elimination of duplicative and underutilized services. One way of assessing the extent of these problems is the development and institution of a single, uniform statistical reporting and cost accounting system as part of any national health insurance system. Second, a system of monitoring and site visits should be instituted.

Finally, cost control means consideration of the human element. It is unrealistic to expect the individual provider, be it a medical center or a private practitioner, to be constantly cognizant of the societal implications of his actions.

Consequently, the regulator must maintain the appropriate perspective, educate the providers of care, and establish incentives for efficiency and appropriateness of care.

EXPERIMENTATION IN ORGANIZING AND DELIVERING SERVICE

American society has favored a pluralistic system of medical care based almost entirely on the ability of the patient to pay. Rather than utilizing primary care practitioners, the affluent have chosen to receive medical services from specialists with admitting privileges at medical centers. Members of the working middle class have had access to prepaid group practices such as Kaiser Permanente, Pubet Sound, and HIP. Yet, the prepaid practice HMO model has not caught on because even the upper middle class has been unable to afford the premiums particularly because of the generous mandated HMO benefits By and large, New York City has no functioning HMO. This model has not solved the needs of the urban environment. What has mushroomed in the cities has been been hospital-based ambulatory care programs, too often skewed towards emergency room episodic care. In addition, shared health facilities or clinics treating predominantly Medicaid patients have brought physicians to the low income areas of the city. However, these facilities have resulted in further abuse of patient care; for example, "ping-ponging," overutilization, increased total expenditures, short patient-doctor encounters, etc. These facilities have contributed to the problem rather than the solution.

While a national health care financing bill should allow experimentation in the organization and delivery of care, adequate mechanisms must be established to analyze the various organizational structures utilized so that we may begin to evaluate their outcomes and determine which delivery systems should be encouraged or discouraged. Pluralism in delivery systems should not be extolled for its own sake.

Medical schools must be encouraged, through financial incentives, to provide the primary care experience to students and to teach them that medicine is a social science as well as a natural science. Our delivery system must find personnel who will improve patient and physician behavior regarding exercise, smoking, alcohol and dietary abuse. The organization of health care should encourage the use of physician extenders to provide health maintenance and primary care services. In addition to recognizing the need and effectiveness of allied health professionals, they must be incorporated into the payment mechanism of any national health insurance proposal.

REIMBURSEMENT FOR SERVICES

A national health care program must be publicly administered and accountable to both those who finance and use the services. It cannot be administered by a fiscal intermediary.

Total public financing of health care calls for total public accountability. Government must assume a direct role in financing and not relegate this responsibility to a third party carrier. The government should control the financing and delivery of services as well as monitoring the quality of care. The use of fiscal intermediaries will diffuse the regulatory mechanism and insulate the provider from accountability

The manner in which government pays the provider must be flexible owing to the present pluralistic health care delivery system. Experimentation using at least the fee for service and capitation methods must be encouraged. Certain health providers may wish to provide a total package of care for their patients and be reimbursed on a capitation basis, while others may continue to experiment with a fee for service mechanism. Under either system, emphasis must be placed on ambulatory care. The reimbursement formula must take into account age, sex, income levels of the population served.

If nothing else, a national health care system should guarantee that every citizen has the opportunity to relate directly to a health care professional who assumes primary responsibility for his or her care. Safeguards must ensure that the patient can change his primary physician. In addition to the delivery of primary care, a system of referrals and linkages must be established to assure delivery of secondary and tertiary services. The emphasis on primary and preventive services will result in less cost to society because utilization of expensive inpatient services will be decreased

CITIZEN INVOLVEMENT

To guarantee flexibility and change, those who provide services must have an ongoing dialogue with those who receive them. The consumer must be able to articulate his problems in a manner such that providers will react and implement changes in the system. More money is not always the answer to improving health care delivery. A proportion of the governing body of any health care system should be composed of those receiving services. A role of the consumer is to monitor services provided to assure patient amenities. Consumers and providers must work together towards a restructuring of our present delivery system. A coalition of consumers and providers can catalyze legislative change.

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All sectors of the medical care system and the entire populace of New York City have or will feel the effects of these cuts.

If a financing mechanism for health care services were operational, health would be relatively insulated from the ravages of the budgetary crisis. Patients would not have to wait 17 weeks for a clinic appointment. Elective surgical procedures would not have to be postponed indefinitely. Clinic patients would not have to be turned away from voluntary hospitals because of an inability to pay.

In another vein, if regulatory mechanisms were more effective and a financing mechanism were operational, the nursing home scandals we have seen publicized this year might not have occurred, duplication and underutilization of services might be decreased.

The net effect of a combined regulatory and financing mechanisms might result in a reduction in the societal costs of services. the delivery of more primary care services, and insulate the health care delivery system from local fiscal problems. These are highly desirable goals.

If, for a moment, we invert our theoretical situation. let us ask the question: how would regulatory and financial mechanisms have impacted upon the City's fiscal crisis. By decreasing the total cost of services and by redistributing the financial costs of underwriting these services, the burden on the municipal government would be significantly decreased.

On behalf of the Public Health Association of New York City, let me thank you for your time and attention.

Mr. Rostenkowski. Thank you, Doctor.

Is there any comment, any interchange, any suggestion?

Dr. Goldstein. I would like to make one general comment, which I think applies to something that 11 of us have said.

There is really nothing free. There is no such thing as free medical care. It is merely a matter of who pays for it, and who determines what we will pay for those services.

It has been said by many, and I think it is true, that the amount of resources that the country can allocate to health is limited. Nobody knows just where that limitation is, but it is limited.

One of the things that I have observed is that there has been an inability of the medical profession to establish what the priorities for care are. Cases that have been in the news lately have concerned using extensive life saving measures for people who it is questionable can survive. In the intensive care unit, costs can run over $1,000 a day. Now, what other medical services could be provided for these funds?

I think it is important for someone to grasp this question and try to find an answer. The medical profession has been unable to establish priorities of how to spend the health care dollars.

If it were an easy solution, it probably would not be before this committee.

Mr. Rostenkowski. Rev. Woelfl?

Reverend Woelfl. Mr. Chairman, I think at least three of us, if I may presume to interpret some things that were said, at least three of us indicated that the only approach to the health delivery crisis is some kind of integrated program, and that would have to be national.

In other words, what we are all complaining about is that the whole area of health care delivery is fragmented.

In other words, there is no interplay between the industry, which provides so many of the essentials for health care and the professionals, as well as the institutions, medical schools, hospitals, and so on.

Now, I think that any approach to the solution of health care is going to have to take the form of a national supervisory organization which sets patterns and controls in a very regulatory way.

The use of insurance has a way of aggravating problems. That is, private and public insurance combinations are bound to be overly costly for the simple reason that they have elements of profit, elements of competition, and elements of business advertisement and so on in addition to the service itself.

Therefore, I submit that if we are trying to provide good health care at a reasonable price, then it is better to do it in a kind of public way as we have done in so many other instances, as I indicated.

I would disagree rather seriously, with Mr. Ginsberg's approach in admitting the need for catastrophic health insurance.

I know as well as everybody else how difficult those cases are, but what I fear is that legislating a program for that particular problem is going to encourage an escalation of costs all the way down the line, and throughout the whole delivery system, because everybody is going to try to get into that category which is covered by that insurance. Everybody from doctors to hospitals to private individuals, and the patient himself, is going to make sure that he has enough need for health care to qualify for catastrophic coverage, which is going to make that whole area so costly that we will not be able to support it.

That is pretty much what has happened in the case of medicare and medicaid.

Mr. Rostenkowski. Mr. Ginsberg?

Dr. Ginsberg. I am glad that Father Woelfl used that last example, because most objections to using an approach that is more market oriented in the provision of health care is a notion that physicians or patients do not respond to economic incentives, but here, we are hearing testimony that in fact patients will use so much medical care so that they jump into these categories, which in the Long-Ribicoff bill means staying 60 days in the hospital or more.

I am glad that there is recognition that people's behavior does respond to economic incentives, but I do not see this is a serious problem for catastrophic benefits.

The general comment I would like to make is that what is being advocated here, at least by Father Woelfl, is a tremendous responsibility on the part of the Federal Government. In a sense, all decisions on medical care resource use will be centralized, but the mechanisms that we are using now, such as PSRO, utilization review, certificate of need, and prosective reimbursement, have not had a good track record so far. I consider them to be all in the experimental stage. Maybe they will work. Maybe they will not.

But I would be very afraid to bring on a system which required these mechanisms to work extremely effectively, or else have phenomenal inflation or tremendous gaps in service availability.

I do not think that proceeding with limited types of national health insurance, such as the type I have outlined, will prevent us from continuing to experiment with these regulatory mechanisms. I am really concerned with having to depend on them to a great extent at this point.

Dr. Barnes-McConnell. My agreement with two of the panelists on the need for universal, comprehensive national health insurance is as strong as my opposition to my colleague from Michigan State, which I did not realize the degree of our conflict before I came here.

The problem with providing care for the poor and indigent only, as suggested by Dr. Ginsberg, is that such care is shown to be substandard.

Further, there are obviously special health care needs of the aged and extensive health care needs of the poor, but most of us tend to forget that for any of us there may be special health care needs at particular points in our lives when we may not be ready for it.

Most of us have life circumstance changes at different points in our lives, retirement, or divorce, for example. I do not mean just catastrophic illness. I mean any kind of a change in life circumstances that upsets one's pattern of living.

This happens to people whose spouses have passed away and left them with children. It does not matter whether they are men or women. It happens to people who have lost jobs. It happens to people who have borderline incomes and find all of a sudden that with the extent of inflation they can no longer meet basic expenses.

These are problems that will alter the level of medical care utilized even in the case of great need, in a strict fee-for-service, curative system.

Now, with universal national health insurance, care for any person will remain the same regardless of the circumstances.

Whatever changes occur in the income or the emotional or social condition, health care will not be a problem. It is the standardization of health care available for everyone, without regard to the particulars of life circumstances that is the most important aspect of a national health insurance program. Individual contributions for services can be based on a progressive formula, but at any given time of need, it is every person's right to have standard health services available to him.

I want to make one more comment about Professor Ginsberg's remarks. He stated that he wanted the poor to be able to use more health services.

I would like to suggest that we are not after greater utilization of services by the poor so much as we are after raising the level of health among the poor.

We want people to be healthier. Now, it may mean to be healthier, particular kinds of services will be used less. This may be especially true if we are talking about curative health services.

As my statement earlier pointed out, there are all kinds of other possibilities within the framework of health conservation, and there are many that I did not mention. There are programs in exercise physiology, for example, or stress prevention, working with community groups to deal with all forms of community stress, people working together. There is a long list of possibilities, many of which are not widely known.

Finally, I like to point out that the Utah plan that spurred the PSRO impetus did show that there was a reduction in hospital utilization with the very excellent peer review cost containment process.

Therefore, the cost to a hospital would actually go up because of fewer people using the provided services.

The fixed cost for the hospital remains the same or increases because of the constant development of new and more expensive equipment and technology and the increase in malpractice insurance.

To meet this changing pattern, hospitals must be encouraged through the reimbursement mechanism to become more involved in community activities and community health education, broaden the outreach function, and broaden the ambulatory possibilities in order to more realistically meet the needs of both providers of health care and the population in general.

Mr. Rostenkowski. Mr. Duncan.

Mr. Duncan. I have no questions. I thank the panel. You have been very helpful.

Mr. Rostenkowski. Dr. Ginsberg, are you suggesting to us that we change the tax treatment of health insurance premiums even before we enact national health insurance?

Dr. Ginsberg. Yes, I would suggest that. I believe that reducing too much health insurance, I think, too many non-poor individuals have health insurance for routine medical expenses, which are better not being insured, and paid out of pocket by them.

Mr. Rostenkowski. Would you prohibit people from buying first-dollar coverage?

Dr. Ginsberg. I do not favor prohibiting people. I do favor encouraging people not to buy first-dollar coverage. I would consider withdrawing a subsidy to first-dollar coverage.

Mr. Rostenkowski. I want to thank you all for joining us this afternoon. It has been a long day, but we appreciate your patience. I am sure your testimony will be helpful when we sit down in executive session to write national health insurance.

The committee will stand in recess until 1 p.m. tomorrow afternoon.

[Whereupon, at 4:33 p.m., the subcommittee adjourned, to reconvene at 1 p.m., Wednesday, November 19, 1975.]

NATIONAL HEALTH INSURANCE

WEDNESDAY, NOVEMBER 19, 1975

U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON WAYS AND MEANS,
Washington, D.C.

The subcommittee met, at 1 p.m., pursuant to notice, in the committee hearing room, Longworth House Office Building, Hon. Dan Rostenkowski (chairman of the subcommittee) presiding.

Mr. ROSTENKOWSKI. The subcommittee will come to order.

Dr. Nowell, Dr. Cogger, Mr. Heimann, and Mr. Rozak, if you will, take your places at the table.

I want to welcome you to the committee this afternoon. I would like to give you a brief idea of how the subcommittee operates.

We will give you an opportunity to make your presentation, and at the conclusion of the last witness' presentation, we encourage an interchange. This, we hope, will help us write a better record.

If there is something you disagree with that another panelist has said and you want to point it out, you may do so. After that, the members of the subcommittee will join in the discussion and ask questions.

So, Dr. Nowell, if you will begin by identifying yourself and proceed with your testimony, the committee is ready to receive it.

A PANEL CONSISTING OF JOHN FRANCIS NOWELL, M.D., TREASURER, AMERICAN ASSOCIATION OF OPHTHALMOLOGY, ACCOMPANIED BY WARREN MAGEE, COUNSEL; THOMAS J. COGGER, PRESIDENT, COALITION OF INDEPENDENT OPHTHALMIC PROFESSIONALS, ACCOMPANIED BY BRAINARD E. PRESCOTT, COUNSEL AND DIRECTOR; FRANKLIN D. ROZAK, VICE PRESIDENT, PUBLIC AFFAIRS, NATIONAL ASSOCIATION OF OPTOMETRISTS AND OPTICIANS, ACCOMPANIED BY BENNY KASS, COUNSEL; AND RICHARD A. HEIMANN, PRESIDENT, OPTICIANS ASSOCIATION OF AMERICA, ACCOMPANIED BY DONALD S. DAWSON, COUNSEL, AND J. A. MILLER, EXECUTIVE DIRECTOR

Dr. NOWELL. Thank you, Mr. Chairman and members of the subcommitte. I want to express my appreciation for the opportunity to speak to the members of this subcommittee on health today. My name is John Francis Nowell; I am a physician, a graduate of the University of Maryland School of Medicine, licensed to practice medicine and surgery in Maryland, Virginia, and the District of Columbia. I am in the private practice of general ophthalmology in Annandale, Va. Today, as its treasurer, I am representing the American Association of Ophthalmology.

With me is Warren Magee, our legal counsel, in case you have legal questions later.

Ophthalmology is that portion of the practice of medicine which comprises all aspects of care of the eye and visual system, including the prescribing of glasses and other optical devices, the diagnosis of diseases and the medical and surgical treatment of the eye and its related structures. The practice of ophthalmology is included in the practice of medicine and surgery, therefore, the services of ophthalmologists would be provided in medical and surgical benefits described in the various proposals before you.

Ophthalmology is based entirely upon sound and accepted scientific method and principles. It is the first medical specialty to have set up a board of examiners to determine the competence of its practitioners. I may add that it is the first specialty to initiate continuing education.

Ophthalmologists serve half the people who seek care for eye complaints in the United States. Ninety percent of those people are self-referred. Thus the ophthalmologist is a primary health care provider and a primary point of entry into the health care delivery system.

The members of the American Association of Ophthalmology are concerned about several aspects of the proposed forms of national health insurance: possible overburdening of the taxpayer, benefits which may be self-serving to special interest groups, and benefits which may not be what they seem.

The taxpayer should not be expected to pay for benefits for people who can afford them. Medical care in the United States is generally satisfactory and will remain so if it is not too drastically altered. Improvements in care and financing of care in the inner city, and in some remote areas, and among underprivileged groups are indicated. Provision for catastrophic illness is necessary.

However, the provision of eyeglasses and optical devices should not be included in national health insurance. The British National Health Service discovered eyeglasses to be one of the most expensive and least acceptable benefits it provided, contributing to its decline and failure as a desirable health care delivery system. In this country eyeglasses are already being provided to the needy by medicaid legislation, by the Lions Clubs and by other groups.

Spectacles have become popular only in the last hundred years because increasing numbers of people need to read small print and to drive automobiles. Lack of spectacles or improper refractive correction may lead to discomfort or blurred vision but does not cause loss of vision or blindness except in "lazy eye" in small children. Lack of proper medical evaluation of the eyes may lead to blindness by not detecting treatable diseases.

Your committee and others may hear much testimony from represenatives of the fitters and providers of eyeglasses who would benefit financially from inclusion of such devices in national health insurance benefits.

Several bills provide for "vision care." Vision is a function and, strictly defined, cannot be cared for. Care can be provided for the organ system which provides the function, in this case the eye. Eye care can be provided only by physicians, the recognized experts in the detection, diagnosis, and treatment of diseases. "Vision care" is thus a misnomer which has come to be recognized as synonymous with optometric services which are, strictly defined, the fitting and providing of optical devices. Such services have been defined by the Congress in the optometric statute for the District of Columbia. Congress defined optometry as the examination of the human eye to ascertain refractive errors and the fitting of lenses for the correction thereof. As thus defined by Congress, optometrists cannot diagnose or treat the eye in sickness or in health, that being the practice of medicine.

Optometric services have recently been broadly defined in several States to include the detection and diagnosis of diseases. The determination of the presence or absence of disease is the most difficult of medical tasks and requires the greatest of education training, skill, and experience. When nonmedical services are specified as a substitute for medical benefits, one may evaluate the two as being separate but equal. Whether such services are in fact equal has not been determined and serious differences of opinion exist on this point. We are aware of no evaluation by accreditation authorities of the knowledge and skill of optometrists to detect or diagnose diseases which has included an ophthalmologist or an ophthalmic pathologist, who are the recognized authorities on eye disease. The fact that optometric services are separate from medical services is the main stumbling block to truly meaningful and beneficial teamwork between the two disciplines.

If the Congress should decide to include spectacles and optometric services in national health insurance benefits, safeguards must be set up to protect the public against unjustified claims of expertise and against having optical devices prescribed for them unnecessarily.

The American Association of Ophthalmology supports H.R. 6222 as the most reasonable of the proposals before the Congress providing needed financing for medical care without bankrupting the country.

I thank you again for allowing me to appear here today and I will be happy to answer any questions which you may have.

Mr. ROSTENKOWSKI. Thank you, Dr. Nowell.

Mr. Cogger?

STATEMENT OF THOMAS J. COGGER

Mr. COGGER. Chairman Rostenkowski, and members of the subcommittee: I am Thomas J. Cogger, president of the Coalition of Independent Ophthalmic Professionals. I am licensed by the State of New York as an Ophthalmic Dispenser and Contact Lens Practitioner and practice in New York City. I'm past president of the New York State Society of Dispensing Opticians, past president of the Contact Lens Society of America, and currently chairman of the New York State Board of Examiners for Ophthalmic Dispensing. I also teach anatomy and physiology of the eye, and contact lens fitting in the ophthalmic dispensing college in New York.

With me is Brainard E. Prescott, our counsel and director.

My organization represents independent professional ophthalmic dispensers. The coalition is comprised of four major professional organizations: The Society of Dispensing Opticians, Inc., of New York State, having a membership of over 650 active members, the Contact Lens Society of New York State, Inc., having a membership of 300 active members, the Guild of Prescription Opticians of New York State, Inc., representing proprietary interests of over 150 establishments in New York State, and the Contact Lens Society of America, Inc., with over 600 memberships located in almost every State throughout the United States. In addition to these professional organizations, our rapidly expanding membership includes individual professional ophthalmic dispensers from New York, Minnesota, Kentucky, Oregon, Oklahoma, and Texas.

We, in the coalition, differ from other ophthalmic organizations in that we do not think of ourselves as retail sales organizations, but rather as skilled professionals who fit and adapt eyeglasses, contact lenses, artificial eyes, and other therapeutic devices for the aid or correaction of anomalies, deficiencies, and deformities of the human eye.

Because there always seems to be some misunderstanding of the various professional groups who relate to the human eye, let me restate the three basic classifications. These are the opthalmologists, the ophthalmic dispenser, and the optometrist.

First is the ophthalmologist, a medical doctor with special training in all phases of eye care and treatment. Where glasses or contact lenses are indicated, he ordinarily prepares a prescription. This prescription states the visual correcting requirements of a patient. It is this prescription which the ophthalmic dispenser follows in designing, adapting and fitting lenses to meet the individual requirements of the patient.

The second classification is the optometrist, who is permitted to determine the visual correcting requirements by refraction, the results of which is called a prescription. We may then write this prescription, but he usually fills it himself. It is important, however, to note that dispensing services are functions which are separate and apart from prescribing. Whether they are provided by the prescriber or by a dispensing optician, both services should be considered and funded separately.

Ophthalmic dispensers constitute the third classification and should be specifically identified as providers. When a duly qualified practitioner fits eyeglasses, contact lenses, artificial eyes and other therapeutic devices extraocularly, he is performing ophthalmic dispensing services. Call it by any other name, it still boils down to the same identical function. The optometrist calls it optometric services. The ophthalmologist considers it part of medical practice. The dispensing optician calls it ophthalmic dispensing.

Good vision care is such a vital part of our social structure today that it must of absolute necessity be considered in any evaluation of national health programs. It enters every part of our life. Without good vision, our earning capabilities are greatly limited. Poor vision jeopardizes our safety as well as that of others. Without satisfactory vision we are deprived of much of the joy of living.

Pragmatically, we cannot, however, expect that all of the cost of good vision can be absorbed as part of any national health plan. Presently the optical industry is a $3 billion a year business that is expected to grow to between $3.9 and $4.4 billion by 1980. Per capita expenditures for eye wear goods are expected to rise accordingly from $13.50 to $18 by 1980. Based on these figures, it is wholly impractical to expect any major part of vision care to be included in any national health plan.

As we understand the situation, the Congress is considering two major plans. The language of one such bill being considered, covering catastrophic health insurance, provides extensive coverage for eye care and materials as provided by the optometrist. This bill, the Long-Ribicoff S. 2470, states as follows on page 72:

> (b) (1) The term "health care expenses," when applied to any individual or family, means (subject to paragraphs (2) and (3) reasonable expenditures by or on behalf of such individual or members of such family (as the case may be) for any of the following:

Among which services are listed on line 19 of page 72 and on lines 1 through 4 of page 73, respectively, as items (F) and (L):

> (F) optometrist's and podiatrist's services,
>
> (L) prescribed drugs, dentures, durable medical equipment and related supplies, and prostetic devices, and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist,

The language of the comprehensive health program, on the other hand, provides for broadened vision services which include eye care coverage for children and senior citizens, under optometric services. In order that there shall be no misunderstanding of the intent of health care connected with dispensing services, our counsel will submit clarifying language.

Whatever plan is adopted will in a large measure be determined by budgetary restrictions. In any event, we want to point out the following principles to this committee:

1. Ophthalmic dispensing service is a separate function, separate from prescribing. It is neither a medically ophthalmological or optometric function. Consequently, any legislation pertaining to eye care involving the aid or correction of deficiencies, deformities and anomalies of the human eye must specify "opthalmic dispensing services performed by duly qualified practitioners."

2. We are a professional group. We are licensed under State examination proceedings in 19 States. Our group seeks to raise the level of the profession. We do not consider ourselves as retail salesmen. We support continuing education and better schooling within institutions giving accredited courses in ophthalmic dispensing.

3. We believe that particularly in the field of eyeglasses, persons should have freedom of choice in the selection of their dispensing agent and in the style and quality of frame, with a maximum allowance fixed by law. Make no mistake about it, there is an active skirmish in the eye care field over the role eye care professionals play. This is motivated solely by economics. Overprescribing and other ills associated with funded insurance programs such as medicaid can be substantially reduced by allowing the patient freedom of choice without coercion by the prescriber as to who should provide dispensing services. Allowing the patient to select another qualified practitioner, other than the prescriber, to perform the dispensing services would go a long way to reducing costs and the temptation to overprescribe.

4. The provider should be paid the usual, customary fee for services and materials, and in turn, the provider is expected to be obligated to serve the public in the most efficient possible manner.

5. Qualified opticians in active practice should be included in all decisionmaking levels in a national health insurance program pertaining to eye care.

We work in a limited field and it is our objective to maintain the highest possible standards within that field. To that end, we believe that a person adapting and fitting eyeglasses, contact lenses and other ophthalmic devices should be highly qualified educationally, from accredited institutions, and licensed or certified as an ophthalmic dispenser. The need for technical personnel in the eye care field is growing daily. To allow lower standards for profit motives would be a great social disservice.

We appreciate the opportunity to appear so that we can publicly concur with the position of other ethical professions that above all, any system of national health insurance in this country must be based on the professional integrity, educational skills and initiative of individual professional practitioners. In our profession, a retail philosophy can never be a substitute for professionalism.

Thank you.

[Attachment to the prepared statement follows:]

SUMMARY SHEET

I. The Coalition of Independent Ophthalmic Professionals.

A. Membership.

1. Society of Dispensing Opticians, Inc. of N.Y. State.

2. Contact Lens Society of New York State, Inc.

3. Guild of Prescription Opticians of New York State, Inc.

4. Contact Lens Society of America, Inc.

5. Individual professional ophthalmic dispensers.

B. Philosophy.

1. Opposed to the retail sales philosophy.

2. Professional integrity.

II. Eyecare Professionals.

A. Ophthalmologist—medical doctor trained in all phases of eyecare and treatment.

B. Optometrist—determines visual correcting requirements by refraction—may be a prescriber and a provider.

C. Ophthalmic Dispenser—specifically identified as a provider.

III. Prescribing and Dispensing are separate functions.

A. Any legislation pertaining to eyecare involving the aid or correction of deficiencies, deformities and anomalies of the human eye must specify "ophthalmic dispensing services performed by duly qualified practitioners."

IV. Comprehensive health care limitations.

A. Good vision care a vital part of life and must be considered in any national health program.

B. Because of high cost and budgetary restrictions we cannot expect the cost of good vision care to be entirely absorbed as part of any national health plan.

V. Provisions for eyecare services and materials; contact lenses, eyeglasses, artificial eyes and other therapeutic devices.

A. Eyecare and materials as provided by an optometrist covered in catastrophic health insurance bill S. 2470.

B. Comprehensive health program provides broadened vision services for children and senior citizens, under optometric services.

VI. Licensing and Professional Standards.

A. Ophthalmic dispensers licensed in 19 states.

B. Support given to continuing education and the upgrading of education within institutions giving accredited courses in ophthalmic dispensing.

VII. Patients—freedom of choice for dispensing services.

A. Freedom of choice without coercion by prescriber.

B. Freedom of choice a preventative to rising costs and over-prescribing.

VIII. Reimbursement for providers.

A. Proper reimbursement for services and materials.

B. Efficient and exacting service by providers in turn.

IX. Peer Review to include allied professions.

A. Peer review for prescribers and dispensers to include members of all three professions in eyecare.

X. Controlling abuses.

A. Freedom of choice given to patient and proper and effective peer review are necessary to safeguard integrity of eyecare profession.

XI. Quality Standards.

A. All persons adapting and fitting eyeglasses, contact lenses and other ophthalmic devices should be highly qualified educationally from an accredited institution and licensed or certified as an ophthalmic dispenser.

B. The employment of unqualified and untrained "assistants" for profit motive is unethical and a social disservice.

C. Any system of national health insurance must be based on the professional integrity, educational skills and the individual initiative of the professional practitioner.

D. A retail sales philosophy can never be a substitute for professionalism.

Mr. ROSTENKOWSKI. Mr. Heimann?

STATEMENT OF RICHARD A. HEIMANN

SUMMARY

The Opticians Association of America represents the majority of America's dispensing opticians who are also known as ophthalmic dispensers. Together with ophthalmologists and optometrists, opticians provide the optical products and ophthalmic dispensing services to the nearly 100 million Americans who wear eyeglasses or contact lenses in order to correct problems of visual acuity.

By actively competing among themselves, as well as with other providers, dispensing opticians help to insure that high quality optical products and services continue to be available at economical prices at a time when other health care costs are skyrocketing.

If the state of the economy is such that Congress sees fit to enact national health insurance legislation which covers vision care benefits, the Opticians Association of America has formulated eight recommendations that should be included in that legislation. The Association believes that the principles contained in its recommendations will help to maintain competitive cost and quality control incentives and insure continuing access by consumers to their choice of corrective eyewear. Accordingly, national health insurance legislation which includes vision care benefits should:

1. Offer coverage for corrective lenses and frames whenever eye examinations are provided.
2. Require minimum standards for dispensing opticians.
3. Provide specific recognition for dispensing opticians as qualified providers.
4. Guarantee beneficiaries freedom to choose among qualified providers.
5. Distinguish between the prescribing and dispensing functions.
6. Include a reimbursement schedule for basic eyewear based on usual, customary, and reasonable charges.
7. Include an allowance for lenses, frames, and other corrective visual devices.
8. Include opticians on any program design, management and utilization review committees.

Mr. HEIMANN. Mr. Chairman, I am president of the Opticians Association of America. With me today are our general counsel, Donald S. Dawson of the firm Dawson, Riddell, Taylor, Davis, and Holroyd, and J. A. Miller, our executive director.

I appreciate this opportunity to supplement and amplify the testimony on national health insurance presented to the Committee on Ways and Means by the Opticians Association of America on June 21, 1974.

OPTICIANS ASSOCIATION OF AMERICA

The association I represent speaks for the majority of America's dispensing opticians, also known as ophthalmic dispensers, who along with ophthalmologists and optometrists, provide optical products, including eyeglasses and contact lenses, and ophthalmic dispensing services to the nearly 100 million citizens who wear corrective lenses.

Through its optical dispensing firms section, the Opticians Association of America represents more than 800 retail optical firms with over 2,000 retail outlets in every State in the Union. There, firms range in size from small proprietorships and partnerships to large multi-State corporations. Three-quarters of our member forces, however, are small businessmen whose annual gross sales volume is under $150,000.

Through its member State society section, the OAA also represents 34 State opticians' societies, most of whose members are also employed in an independent retail setting. The remainder render ophthalmic dispensing services as employees of licensed ophthalmologists and optometrists or in such institutional settings as hospitals, clinics, health maintenance organizations, and military bases.

Dispensing opticians design, take the necessary measurements, and deliver to the doctor's patients lenses, frames, and other specially fabricated optical devices on the basis of prescriptions written by ophthalmologists and optometrists.

Optical or ophthalmic dispensing includes, but is not limited to, prescription analysis and interpretation; the taking of measurements to determine the size and shape of the lenses, frames, or lens forms needed to obtain the desired optical correction; the preparation of work orders for optical laboratory technicians who grind lenses and fabricate corrective eyewear; the verification of the accuracy of finished lenses; the adjustment of lenses or frames to the intended wearer's face or eyes; and the replacement, repair, and reproduction of previously prepared ophthalmic lenses, frames, and other specially fabricated optical devices.

By openly competing among ourselves as well as with those ophthalmologists and optometrists who dispense eyeglasses, America's dispensing opticians perform an extremely important function in the marketplace for corrective eyewear. Because our livelihoods are completely dependent upon filling prescriptions for eyeglasses, opticians must provide high quality products and services to the public at competitive prices. These competitive factors and incentives for both quality and cost control serve to protect consumers' pocketbooks and insure proper eye care in the best interests of the public. We will become even more important if Congress decides to enact an expanded system of national health insurance.

In the interests of preserving quality and cost control incentives in any national health insurance program that includes vision care benefits, the Opticians Association of America recommends that the following provisions be included in enabling legislation or accompanying administrative regulations.

1. COVERAGE FOR CORRECTIVE LENSES AND FRAMES WHENEVER EYE EXAMINATIONS ARE PROVIDED

In our opinion, it will serve the public to cover diagnostic vision care services without also including provisions for such corrective dispensing services and materials as may be prescribed by the examining vision care doctor. These would be subject, of course, to such limitations as may be needed to keep costs within manageable limits.

2. MINIMUM NATIONAL STANDARDS FOR DISPENSING OPTICIANS

Any national health insurance program that provides eyeglasses should require each provider of optical products and related services to meet minimum national standards. The Opticians Association of America endorses the principle of establishing nationally recognized standards for all providers of ophthalmic products and optical services and of requiring continuing education in order to insure that both products and services keep pace with ophthalmic technology.

To this end, our association has established a national registry under which member firms obligate themselves to make sure that the dispensing opticians they employ have established their qualifications by either obtaining a valid State license, by being certified by the American Board of Opticianry, or by having successfully completed a performance based registration examination administered nationally by the Educational Testing Service of Princeton, N.J., on behalf of the association.

In addition, each dispenser is required to maintain his competence by meeting continuing education requirements. Opticians so qualified by such credentialing should be eligible to participate in national health insurance programs that include coverage for eyeglasses and contact lenses.

3. SPECIFIC RECOGNITION FOR DISPENSING OPTICIANS AS QUALIFIED PROVIDERS

Because dispensing opticians represent a very large segment of the suppliers of eyeglasses to the public—and provide for a competitive base for the Nation's eyewear delivery system, it is crucial that those who meet nationally accepted standards of competence be recognized as qualified providers of optical products and ophthalmic dispensing services which are covered in any legislation.

4. FREEDOM FOR BENEFICIARIES TO CHOOSE AIMING QUALIFIED PROVIDERS

In any program of coverage for eyeglass benefits that provides quality products and services at reasonable costs, the critical ingredient is a specific guarantee for corrective eyewear filled by the vision care doctor or dispensing optician of their choice. Therefore, any legislation, should provide that eligible beneficiaries may take their prescription to a qualified provider of their own choosing. This will insure the competition that helps to assure high quality and at the same time maintain prices at levels that people can easily afford.

5. DISTINGUISH BETWEEN THE PRESCRIBING AND DISPENSING FUNCTIONS

Any program that includes vision care benefits should also be required to distinguish between the services and charges connected with eye examinations and the writing of eyewear prescriptions on the one hand, and those associated with the fabrication and dispensing of the eyewear that has been prescribed on the other. Examining and dispensing are two separate functions and should not be confused. Such a requirement is needed to separate the service and charges of the eye doctor in examining eyes from the dispensing services and charges for eyeglasses and contact lenses that may be performed either by the same eye doctor who made the examination or by an independent optician. Failure to separate such services and charges could result in an inadequate amount being allowed to the dispensing function, thereby reducing the dispensing optician's ability to compete with the refractionists in providing eyewear under a national health insurance program.

6. REIMBURSEMENT SCHEDULE FOR BASIC EYEWEAR BASED ON USUAL, CUSTOMARY, AND REASONABLE CHARGES

Any national health insurance program which offers vision care benefits should include a schedule for reimbursing qualified providers which is based on usual, customary, and reasonable charges for materials, materials processing, operating costs, and the dispensing services needed to meet the visual requirements of eligible beneficiaries. Provisions should also be made for an annual review of this reimbursement schedule to insure its continuing adequacy. This is particularly important in periods of rapidly increasing costs.

7. ALLOWANCES FOR LENSES, FRAMES, AND OTHER CORRECTIVE VISUAL DEVICES

Fashion, appearance, and comfort are critical determinants of people's willingness to wear eyeglasses. For this reason, the association believes that eligible beneficiaries should have the option of being able to apply the basic eyewear reimbursement amount as an allowance toward payment for eyewear of their choice.

Such an allowance should be administered in such a way as to maintain the dignity of each beneficiary and prevent his being stigmatized by the standardized "GI" pair of eyeglasses.

8. OPTICIANS PARTICIPATION IN PROGRAM DESIGN, MANAGEMENT, AND UTILIZATION REVIEW

In the best interests of the public as well as the providers of ophthalmic products and optical services our association recommends that dispensing opticians be represented on all governing or advisory committees that may be established to plan, oversee, and evaluate any national health insurance program which provides eyeglasses or contact lenses as benefits. This participation is particularly important in policy or related rulemaking concerning (1) quality of materials, (2) levels of service, (3) safeguards against overutilization, and (4) the establishment of fair and reasonable charges of ophthalmic products and optical dispensing services.

CONCLUSION

In summary, the Opticians Association of America is convinced that the American people stand to derive the greatest benefit from a national health insurance program which (1) offers coverage for corrective lenses and frames whenever eye examinations are provided; (2) requires minimum standards for dispensing opticians; (3) provides specific recognition for dispensing opticians as qualified providers; (4) guarantees beneficiaries freedom to choose among qualified providers; (5) distinguishes between the prescribing and dispensing functions; (6) includes a reimbursement schedule for basic eyewear based on usual, customary, and reasonable charges; (7) allows for lenses, frames, and other visual devices; (8) includes opticians on any program design, management and utilization review committees.

This concludes my statement, Mr. Chairman. Thank you for your attention.

Mr. ROSTENKOWSKI. Mr. Rozak?

STATEMENT OF FRANKLIN D. ROZAK

Mr. ROZAK. Thank you, Mr. Chairman and members of the subcommittee. I am Franklin D. Rozak, vice president for public affairs of the National Association of Optometrists and Opticians, Inc.—NAOO.

Today, I am accompanied by Mr. Benny Kass, Washington counsel for the NAOO. I will note the absence of the American Optometric Association at this hearing, where the majority of us are asked to discuss an important issue. I am sorry to see that they did not come, and I hope there will be an opportunity for them to make some statements and an opportunity by those present to review those statements.

The National Association of Optometrists and Opticians is a nationwide organization representing the retail optical industry. Its membership is drawn from every type of enterprise and person in optometry and opticianry, optical firms and individual optometrists and opticians. NAOO is consumer-service oriented, dedicated to the proposition that the consumer's visual care needs are met most completely and economically by the free market, in the tradition of the American business system. Membership in NAOO consists of owners and management of optometric and retail optical offices. Our organization represents more than 1,100 individual optical outlets with over 10,000 employees. Our latest statistics reveal that approximately 10 percent of all vision care in 1974 was provided by our members.

With the exception of 13 States where in various anticompetitive and anticonsumer laws, rules, and regulations preclude our member firms from free entry into those markets, our association functions on a national basis.

Our basic purpose in testifying this afternoon is to attempt to insure that those anticompetitive restrictions which are operative in certain State jurisdictions do not find credibility and protection with national health insurance legislation—to the detriment of the health of NHI recipients and taxpayers.

In seeking to highlight a number of items for committee consideration, we do not seek to endorse any one NHI bill.

Currently, the Congress has recognized the importance of vision care to the overall health of the individual by enacting, among others, the following:

1. Title 19 of the Social Security Act, commonly known as medicaid;
2. The Health Maintenance Organization Act of 1973; and

3. Title 18 of the Social Security Act, referred to as medicare.

Unfortunately, each of those programs have encountered spiraling costs, an inability to service many of their recipients and essentially, have "turned off" many potential health care providers for a variety of reasons. It is submitted that one of the primary reasons for these failures is: The control exercised by the professions in connection with those programs.

It is not our intent to engage in the dispute between the several vision care professions as it relates to NHI other than to state our belief in the need for a new approach, as follows:

STATE LAWS

1. The ramifications of State laws which are enforced by their State boards responsible for the regulation of the professions of optometry and opticianry ought to be carefully considered by this committee.

Mr. Chairman, incidentally, the Federal Trade Commission announced some few weeks ago an investigation into the restrictive practices of State laws governing the optical industry.

Senator Percy entered into the Congressional Record a chart outlining some of the restrictive practices, on September 24, 1975.

With your permission, I would like to ask this be made a part of the record.

Mr. Rostenkowski. Without objection.

[The information referred to follows:]

FEDERAL TRADE COMMISSION SURVEY OF CURRENT STATE RESTRICTIONS ON EYEGLASS PRICE ADVERTISING

[Key—1. Statutory price advertising prohibition optometrists: U=unprofessional conduct definition; G=grounds for license suspension or revocation other than unprofessional conduct; C=criminal penalties for unlawful price advertising; D=defers power to State board or professional association to define unprofessional conduct. 2. State board regulation price advertising prohibitions (X). 3. State optometric association price advertising prohibitions: S=State association codes of ethics or rules of practice; N=national association (American Optometric Association) code of ethics deferred to by State association. 4.* All forms of media advertising prohibited except announcement of new practice or location. 5.*No advertising of discounts or premium. 6.* Sign and window display limitations. 7.* Telephone directory listing limitation. 8.* Practice in mercantile establishment prohibited. 9.* Employment with unlicensed persons or firms prohibited. 10.* No more than 1 branch office. 11. Opticians prohibited from price advertising by statute or regulation: L=licensing statutes or regulations for opticians contain ad bans: A=all persons designations in optometry statutes extend ban to opticians.* L=prohibited by State law. R=prohibited by regulation. E=prohibited by professional association codes of ethics or rules of practice.]

	Price advertising prohibitions			Other advertising restraints				Business practice restraints			Opticians
	1	2	3	4	5	6	7	8	9	10	11
Alabama	D		S	E	L	E	E	E			
Alaska	D	X				R	R	R			L
Arizona			S		E						
Arkansas	C			L	L	R	R	R			
California	C							R	L	L	L
Colorado			S		L		L				
Connecticut	D	X				R		L			
Delaware			N			R	R	R			
District of Columbia			S		E	E	E				
Florida	C			L	L	R		R	R	R	L
Georgia		X		R				R			
Hawaii	G				L			L			L
Idaho	D	X				R	R		R		
Illinois	C				L	L					A
Indiana	C								L		A
Iowa			N			E	E	E			
Kansas	D	X			R	R	R	R			
Kentucky	C				L	L				L	
Louisiana	C										
Maine	C			E	E	E	E	L			A
Maryland			N								
Massachusetts[1]	C				L						
Michigan	C										A

See footnotes at end of table.

FEDERAL TRADE COMMISSION SURVEY OF CURRENT STATE RESTRICTIONS ON EYEGLASS PRICE ADVERTISING—

[Key—1. Statutory price advertising prohibition optometrists: U=unprofessional conduct definition; G=grounds for license suspension or revocation other than unprofessional conduct; C=criminal penalties for unlawful price advertising; D=defers power to State board or professional association to define unprofessional conduct. 2. State board regulation price advertising prohibitions (X). 3. State optometric association price advertising prohibitions: S=State association codes of ethics or rules of practice; N=national association (American Optometric Association) code of ethics deferred to by State association. 4.* All forms of media advertising prohibited except announcement of new practice or location. 5.*No advertising of discounts or premium. 6.* Sign and window display limitations. 7.* Telephone directory listing limitation. 8.* Practice in mercantile establishment prohibited. 9.* Employment with unlicensed persons or firms prohibited. 10.* No more than 1 branch office. 11. Opticians prohibited from price advertising by statute or regulation: L=licensing statutes or regulations for opticians contain ad bans: A=all persons designations in optometry statutes extend ban to opticians.* L=prohibited by State law. R=prohibited by regulation. E=prohibited by professional association codes of ethics or rules of practice.]

	Price advertising prohibitions			Other advertising restraints				Business practice restraints			Opticians
	1	2	3	4	5	6	7	8	9	10	11
Minnesota	U										
Mississippi	D	X		R				R		R	
Missouri	G				R	E		E			
Montana	G								L		A
Nebraska	U				L						
Nevada	U			R		R		L			L
New Hampshire	G										
New Jersey	G			L	R	L	L	L	L		L
New Mexico	C				S			S			A
New York	D	X			R						L
North Carolina	G			L							L
North Dakota	C			R					L		
Ohio	(2)										
Oklahoma	C			L				L	L		A
Oregon	G				L						A
Pennsylvania	G									R	A
Rhode Island	D	X						L			
South Carolina	C				L			L		L	L
South Dakota	U			R							
Tennessee	G			L							L
Texas	[1] G					E		L			
Utah	[4] U										
Vermont			S								
Virginia	U							L			L
Washington	[1] C			E	L			E			L
West Virginia	[3] G			E				L			
Wisconsin	C			R		L					A
Wyoming	U										A

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[1] Partial ban, only frames and mountings may be advertised—Not lenses or professional services.

[2] Price advertising banned by city ordinance in cities such as Cleveland and Springfield.

[3] Advertising of completed eyeglasses prohibited unless prices broken down as to component parts.

[4] Price advertising prohibited unless accompanied by simultaneous disclosure of quality, grade and special characteristics of the optical article.

Mr. Rozak. I will continue now with my listing of our beliefs.

FREEDOM OF CHOICE

2. NHI legislation should be extending the principle of "freedom of choice" to include the patient's right to has his prescription for ophthalmic goods filled by a vision care doctor or retail dispensing optician of his own choosing.

COMPETITIVE BASE

3. Provide for the explicit recognition for retail dispensing opticians as qualified providers of ophthalmic products and related services. The importance of this recommendation is underscored by the fact that dispensing opticians provide the competitive base for the Nation's eye care delivery system. They engage in competition among themselves. They compete with opthalmologists who dispense eyewear. In addition, competition exists with the 95 percent of the solo-practicing

optometrists whose incomes are largely dependent upon the sale of the very product which they prescribe.

NATIONAL EXAMINATION

4. A national examination should be substituted for local licensing restrictions. It is noted that both the Federal Trade Commission and the Department of Health, Education, and Welfare have concluded that State licensing has one major adverse effect; namely, preservation of the professional vested interest at the expense of competition.

UNDERSERVED AREAS

5. Financial incentives to assure adequate levels of health manpower for underserved population areas.

PEER REVIEW

6. Include representation of all providers of vision care in any utilization/evaluation program—including members from the consuming public.

CONTINUING EDUCATION

7. All providers of vision care should be required to participate in a program of continuing education to avoid obsolescence.

RECIPROCITY

8. A program of national health reciprocity to insure that the flow of health manpower is not impeded by arbitrary decisions of State boards which rarely represent the total profession. An example of the capricious activity of certain State boards is outlined in the U.S. Supreme Court case, *Gibson* v. *Berryhill*, 411 U.S. 564 (1973).

In summary, the NAOO believes that our country will derive the greatest benefit from a national health insurance program that:

1. Preempts the various State laws and regulations which have been heavily lobbied by the several vision care professions, to insure "acceptable levels of professional competition";
2. Encourages competition among the various providers of optical services and products;
3. Mandates the effective utilization of "skill time" which each professional provider offers in the delivery of eyecare; and
4. Includes effective mechanisms for cost and quality control.

Mr. Chairman, on behalf of the NAOO, allow me to thank you for this opportunity to present the views of the Association on this important issue. I will be pleased to attempt to answer any questions which you and the members may have.

Mr. ROSTENKOWSKI. Thank you, Mr. Rozak. This is the opportunity that we afford the panelists to make observations about another person's testimony. Or if you would like to enlarge on anything you have said, this is the time to do that.

Dr. Nowell?

Dr. Nowell. At this point, I would just like to say that, again, the term "vision care" we believe, is a misnomer, and we think in terms of eye care on the one hand, the professional examiner, and on the other hand the optical dispensing. You may call them optical dispensing services, or optical services. I would not disagree with the other members of the panel on that point.

Mr. Cogger. Mr. Chairman, the point to emphasize is this; prescribing and dispensing are two different functions. Dispensing is performed by dispensing opticians as well as optometrists and ophthalmologists. Therefore, we should be cautious about defining vision care as "optometric services," because such language would only permit the optometrist to perform dispensing services.

I find I must take exception to one statement that our last witness testified to, and that is in reference to the State boards.

I can speak from personal experience with respect to the New York State board, having served as its chairman for the last 5 years, and particularly in that phase of the examination for contact lenses proficiency.

We do try to account for mobility between States. It just happens that our particular State in New York has the highest qualifications for ophthalmic dispensers pertaining to dispensing, but this is necessary because the scope of our practice in New York State includes a wide range of dispensing services that other States do no include.

It is not just the dispensing of eyeglasses, but includes other devices such as contact lenses and artificial eyes. The qualifications required to perform those services for the benefit and the welfare of the public are amply protected by the requirements set down by the examination board in New York State.

Thank you.

Mr. Heimann. I have nothing to add at this point, Mr. Chairman.

Mr. Rostenkowski. Mr. Rozak?

Mr. Rozak. Yes, as I indicated earlier, perhaps the unanimity here is the fact that one of the major forces, namely, the American Optometric Association, whose members dispense about 70 percent of the eyewear in this country have determined not to make a statement today.

Mr. Rostenkowski. Mr. Rozak, I would like to point out that they were invited to participate.

Mr. Rozak. I understand that. I don't understand, Mr. Chairman, why they did not come.

With respect to Dr. Nowell, he is absolutely right. I used the term "vision care," I think, and again we have some professional definition problems here, but eyecare and vision care, I think, are somewhat synonymous, but I wouldn't get into a debate with him on it.

The key element, and I want to address myself to something that Mr. Cogger said, and that is, I think, that one of the basic problems that national health insurance is going to have is how are we going to determine the quality of a practitioner. and how much he ought to be charging whoever is going to pay the bill.

In our experience on the national level within my association of the various State boards denying licenses by reciprocity is any indication of the health care personnel flow problems that are going to occur in national health insurance, then we have a serious problem, and I would just note that the Health Maintenance Organization Act of 1973 indicated in one of the sections—it exempted certain State laws with respect to advertising, et cetera, simply on the basis that they knew, the Congress knew in its wisdom that an HMO could not effectively compete with a private health care provider unless they were able to advertise.

So, we have these problems of what is unprofessional conduct and ethical conduct, and I think it gets back to the consumer's right to know.

But I would ask that the committee give serious examination to a national examination with national standards so that everyone knows where he is at, and frankly so there is no hanky-panky that goes on.

There are a number of lawsuits in the various States regarding questions of whether you have passed the exam, or did not.

With that, I have nothing else to say.

Mr. ROSTENKOWSKI. We have three organizations representing opticians here. Can you tell us why you need three organizations? Does each of the organizations represent types of opticians, or pursue different goals? Would anybody care to answer that?

Mr. ROZAK. Well, Mr. Chairman, in deference to Mr. Cogger and Mr. Heimann, opticians are probably no different than a number of other businesses from the vantage point that they operate in different methods.

My organization seeks to either employ an optometrist on a valid basis, or to lease space to them. Other opticians determine that their modus operandi is to develop a positive relationship with an eye doctor, an ophthalmologist, or other physician, wherein he refers patients based upon an awareness of the optician doing a good job and prices are right.

Then there are other opticians that believe any relationship with a doctor, perhaps, is a "no no."

It is unfortunate that the retail optical industry is not united, but that is the animal. I think there are a number of people trying to effectively pull us all together, and hopefully, those efforts will succeed.

Mr. ROSTENKOWSKI. Mr. Heimann?

Mr. HEIMANN. I think the Opticians Association of America basically represents a substantial majority of opticians, and we believe in the separation of the subscribing and dispensing functions, and they can speak for themselves. I think they represent—their primary membership is in New York State, which is not a part of our organization.

Mr. ROSTENKOWSKI. Mr. Cogger?

Mr. COGGER. Our philosophy properly differs, although we are overlapping in a number of functions.

In our instance, our organization emphasizes the independent ophthalmic practitioner. If he is a businessman, he is a professional. He is the one man performing those services directly for the public, the client, or the patient, however you wish to call him.

We feel that we are not—of course, we are interested in making our living, but we are not primarily interested in selling or merchandising. We are interested in providing a service. This service not only includes materials, but the actual designing of a system to correct the visual deficiencies of the human eye, and also the many other ocular anomalies which can be found by designing other devices, such as contact lenses, artificial eyes. These are not products you take off the shelf. It is a service we must provide for a person; not done by operating a chain store or a big business enterprise.

Mr. ROSTENKOWSKI. Mr. Nowell, do ophthalmologists usually refer patients to particular opticians?

Dr. NOWELL. Sir, I don't know that there are any guidelines on that. I think this is up to the individual practitioner. I think the recommended practice is the one I follow personally, that I know from experience who does a good job and I recommend several opticians to a patient. I don't tell people where not to go, but I try to steer them to the ones that I know do a good job.

Mr. COTTER. Would the chairman yield? I might follow up on that. Aren't there financial arrangements between ophthalmologists and opticians? I thought that was a common practice.

Dr. NOWELL. Are you speaking of kickbacks, sir?

Mr. COTTER. That type of thing; yes.

Dr. NOWELL. Undoubtedly some such things exist, but our organization does not advocate it.

Mr. COTTER. I thought it was a common practice?

Dr. NOWELL. No, sir, I would not agree it is a common practice.

Mr. COTTER. But it is not unusual.

Dr. NOWELL. It is rare, but not unheard of, I would say.

Mr. ROSTENKOWSKI. Mr. Rozak, do optometrists engage in kickbacks? Do they refer patients?

Mr. ROZAK. As I indicated in my statement, Mr. Chairman, about 95 percent of the licensed, individual optometrists sell exactly what they prescribe, so you have one-stop service, so to speak, and there is some question about whether the patient really has freedom of choice to take his prescription wherever he wishes when the doctor of optometry has the prescription in is hands. Does that answer your question?

Mr. ROSTENKOWSKI. Mr. Heimann.

Mr. HEIMANN. I just wanted to comment on the prior question, in that as I understand it, the FTC has regulations, and there is a consent decree against illegal rebates.

Mr. ROSTENKOWSKI. Thank you.

Mr. Duncan will inquire.

Mr. DUNCAN. Thank you, Mr. Chairman. I would also like to thank the panel.

Could you tell me how many ophthalmologists are practicing in the United States?

Dr. NOWELL. There are approximately 10,000 ophthalmologists.

Mr. DUNCAN. Do you think that is a sufficient number?

Dr. NOWELL. No, sir; it is not.

Mr. DUNCAN. How many do you think we need?

Dr. NOWELL. Well, with the advent of ophthalmic technicians who can do certain routine tasks for the ophthalmologists, perhaps another 2,000 or 3,000 would be adequate.

Let me make clear, sir, in answer to your question that I, too, regret that the optometrists are not represented here today, and I want to emphasize that our organization is not opposed to optometry. We are not trying to put them out of business. They have a valuable service to render. We feel, however, that they make claims which are unjustified. We also feel that there must be safeguards in optometric services.

So when you speak of how many ophthalmologists we need, you have to take in the whole picture. If optometrists would become aids to ophthalmologists and work in cooperation with them, we have more than enough manpower now.

Unfortunately, organized optometrists oppose this vigorously. They do not recommend that optometrists work for or under the supervision of ophthalmologists.

Mr. DUNCAN. What percentage of the American people would you say do not have easy access to an ophthalmologist?

Dr. NOWELL. Sir, that would depend on your definition of "easy access."

Mr. DUNCAN. Let's say "reasonable," then.

Dr. NOWELL. With respect to reasonable, we have to break down what sort of services you are talking about. If you are talking about emergency services for an eye injury or an infected eye, where a patient must be seen the same day or in a few days, accessibility is good. I would say that there is no place in the United States where an ophthalmologist is more than 1 hour away, driving time by automobile. This has been checked out even in——

Mr. DUNCAN. The reason I asked you this question is that I was, several months ago, at an ophthalmologist in Knoxville that I use, and while I was there, some person called on the phone and the secretary said, "Have you ever been served before by Dr. Ballou?" The secretary added that unless they had in the last 2 years that they wouldn't accept the patient. I got to checking around, and all ophthalmologists of the city were doing the same thing. They weren't taking new patients, and appointments were running anywhere from 6 to 8 weeks. I was wondering how we could correct that situation, if it can be corrected.

Dr. NOWELL. Well, sir, this is a category of services that I did not get to, and that is routine examinations. It is recommended that eyes be checked every 2 years, or less often in certain age groups.

For this kind of nonemergency, nonurgent kind of care, yes, sir, it is true that there are waiting lists up to 3 or 4 months, and some ophthalmologists getting up in years who wish to cut down on their practices have to limit it somehow. They have their choice of either not seeing old patients or not seeing new patients. I think it is certainly not fair to the old patients to curtail them.

However, this, we feel, is adequate care. It does not hurt anything to wait 3 or 4 months for a routine examination, which people have become accustomed to doing all over the country.

Mr. DUNCAN. Is the number of residents in training increasing through the years?

Dr. NOWELL. Yes, sir. I cannot give you exact numbers at this time. I will be glad to furnish them later, but the number of ophthalmologists being turned out by residences is increasing.

Mr. DUNCAN. Could you furnish that for the record for each of the past 5 years?

Dr. NOWELL. Yes, sir.

[The information follows:]

UNITED STATES

Period ending	Total ophthalmologists	Residencies filled
Dec. 31, 1970	9,927	1,360
Dec. 31, 1971	10,252	1,403
Dec. 31. 1972	10,443	1,472
Dec. 31, 1973	10,496	1,500
Dec. 31, 1974	10,741	1,419

Source: American Medical Association, Division of Medical Education and Center for Health Services Research and Development, Chicago, Ill.

Mr. DUNCAN. Isn't it true that in optometry most State laws say that you can't diagnose abnormalities, and then you refer the patient to ophthalmologists. Don't you run a risk of malpractice if you fail to do so?

If this is the case, why shouldn't you be reimbursed for diagnostic services?

Mr. ROZAK. I was not speaking of the question that ophthalmologists should not be reimbursed for services.

Mr. DUNCAN. I know you didn't.

Mr. ROZAK. The issue of diagnosis of medically related problems, I think that to be answered better by Dr. Nowell and his counsel, but at my last count, the indication was that only seven or eight States in the statute governing the practice of optometry permitted optometrists to use drugs in connection with their practice. Then there are, according to my information, there are another 8 to 10 States wherein the statute is silent on the issue of whether or not optometrists can use drugs in connection with their practice.

On the malpractice question, I really have no information on that at all.

Mr. DUNCAN. My time is up. Thank you very much.

Mr. ROSTENKOWSKI. Thank you.

Mr. Cotter will inquire.

Mr. COTTER. Thank you, Mr. Chairman.

Dr. Nowell, are there any instances where ophthalmologists also grind and fit eyeglasses as well as examine?

Dr. NOWELL. The only statistics we have on that, sir, are in the 1960's, and the data then indicated that approximately 40 percent of ophthalmologists also dispensed eyeglasses.

Mr. COTTER. I would guess that would be decreasing. Is that right?

Dr. NOWELL. I would not venture to say, sir.

Mr. COTTER. You made a statement that if optometric services were included under a national health insurance program, that safeguards would be needed to protect the public against unjustified claims. Can you elaborate on that?

Dr. NOWELL. Yes, sir. Recently, organized optometry has made the effort to expand the definition of the practice of optometry to include the detection and diagnosis of diseases. Several laws have been passed in several States to that effect, as Mr. Rozak referred to, even including the use of certain drugs.

We, as physicians, feel that this is a practice of medicine and our legal counsel can give you legal definitions if you wish, sir, but let me go back and say again that we don't object to optometrists practicing optometry as defined in the District of Columbia statute.

Mr. Cotter. That is, making glasses?

Dr. Nowell. That is correct. However, when they venture forth as they have in the past 2 or 3 years into the new aspect of the practice of optometry, claiming they can detect diseases, we take exception to that.

Mr. Cotter. You don't think they have the training to do this correctly?

Dr. Nowell. That is correct. In their schools, they list all sorts of courses on pathology, and so forth, which on reading would have you believe they know everything we learn in medical school, but there has been no proof that these individuals are really trained to do what they say they can do. This, I think, is very important. We must protect the public on this point.

Mr. Cotter. Sir, could you give me the number of Americans who wear glasses?

Dr. Nowell. The number of what, sir?

Mr. Cotter. The number of citizens in this country who wear glasses? Does anyone have that figure?

Mr. Heimann. We think it is about 100 million.

Mr. Cotter. The last time I went for an eye examination and glasses, it was a $100 bill between the two. It was like $50 for the examination and $50 for the glasses, which means that if I go every 2 years, that averages out to $50 a year, and how many million, $50 million?

That is $10 billion per 2 year—$100 million times $100. My arithmetic isn't too good, but that is $5 billion a year it is going to cost us to provide the examination and the glasses under a national health insurance program? I just can't see how we can afford it.

Now, another thing, Dr. Nowell, you mentioned here that lack of spectacles or proper refractive correction may lead to discomfort or blurred vision, but does not cause loss of vision or blindness, except in lazy eye in small children.

I think that statement right there is enough to demonstrate that we shouldn't include eyeglass service under a national health insurance program.

Dr. Nowell. May I respond to that, sir?

Mr. Cotter. Yes.

Dr. Nowell. That is exactly my point. I think there is a myth that glasses, or the improper use of glasses, or improperly fitting glasses will damage your vision from so-called eystrain. I think this is really a myth.

Mr. Cotter. I think we could rationalize that providing shoes for everyone in America under the national health program because it would protect their feet as well as we can rationalize providing eyeglasses.

I can see examination in case of disease and this kind of thing, but to provide the glasses themselves. I think it is unconscionable. Also I am concerned about abuse—what can we do to prevent paying for glasses because "styles" change.

Dr. Nowell. This is one of the reasons that we recommend eyeglasses not be included in the benefits.

Mr. Cotter. Thank you very much.

Mr. Rostenkowski. Mrs. Keys will inquire.

Mrs. Keys. Thank you, Mr. Chairman.

Thank all of you for your testimony. It has been most enlightening. I have just one question, and I would like a short response from each of you.

Do you feel that eye care, which would include corrective vision if necessary, is a basic ingredient of health care?

Dr. Nowell. Was your question, would it include corrective vision?

Mrs. Keys. No. The question was very simple.

Do you feel that eye care which would include visual correction if necessary, is a basic ingredient of good health?

Dr. Nowell. Yes.

Mrs. Keys. I would like a quick response from each of you.

Mr. Cogger. Yes; I do.

Mr. Heimann. I think I would have to answer that yes, also.

Mr. Rozak. In the affirmative.

Mrs. Keys. Thank you. I just wanted an answer to that question.

Thank you very much.

Mr. Rostenkowski. Dr. Nowell, when a person has had a cataract operation, would it be appropriate for him to see an optometrist to get the prescription for his lens?

Dr. Nowell. Mr. Chairman, "appropriateness" I don't quite follow. Certainly it would be not essential that he consult an optometrist. The ophthalmologist who did the surgery is also capable of measuring the refractive error in the eye and prescribing glasses. We have no objection to having a qualified optometrist do that. Does that answer your question, sir?

Mr. Rostenkowski. Are there any further questions of this panel?

I want to thank you gentlemen for appearing and helping us in writing a record that ultimately will help us put together a national health insurance program.

Thank you.

Mr. Heimann. Thank you.

Mr. Rostenkowki. If Mr. Trautman and Mr. Howard will please take the witness stand, we will then continue in 2 minutes.

[A recess was taken.]

Mr. Rostenkowski. The subcommittee will come to order.

I want to welcome Mrs. Howard and Mr. Trautman to the committee.

If you like, Mrs. Howard, please identify yourself and begin your statement.

STATEMENTS OF RUTH P. HOWARD, BURLINGTON, MASS., AND DONALD D. TRAUTMAN, CHAIRMAN, LEGISLATIVE COMMITTEE, NATIONAL ASSOCIATION OF HOME HEALTH AGENCIES

Mrs. Howard. I am Ruth Howard, a homemaker from Massachusetts, and I came into contact with hospitals 2 years ago, and how people were treated, and what will happen, for instance, if people need home help, and so I started writing to everybody, and I will start my statement.

I thank you for this chance to speak to you about a national health bill, which should include fiancial aid to expand professional homemaker services across the country.

I am not a doctor, nurse, social worker, labor leader, or member of an insurance group. I am a member of that group which goes along with the American flag and apple pie—a mother.

During my 2 years' of illness and six hospital stays—if you would like to know, I have an inoperable brain tumor—I have amassed information on the problems and possible solutions that face the average family when the mother is ill for a lengthy period of time. The emotional stress and financial drain on the family, despite medical insurance coverage, are but two problems that must be faced. There are other problems, but for middle- and low-income, self-sustaining families, there two problems are major and should be considered when you vote for a health bill.

In ordinary times, the wife and mother frees the "breadwinner" to go to work every day. Year in and year out, millions of dollars are lost by industry due to the breadwinner's staying home to take care of the household while the mother is sick and recuperating. If the mother is completely incapacitated or dies, other problems accrue.

When a man gets sick or dies, there is Social Security to help the family through financial difficulties. Not so for a woman who has chosen the career of being wife, mother, and homemaker. The family will receive social security benefits only if the woman has worked 20 quarters or 5 years in the last 10 years. As an example, I worked 6 years before I stopped to have a family. Unfortnately, I only worked 3 years in the last 10. My master's degree in guidance counselling looks good on paper but does not help with the financial difficuties my illness has created. Going one step further, my training indicated to me that raising my children full-time was vital in other that they grow up to be responsible adults. That decision, however, made for the good of the family, has backfired. My illness and impending death threatens to financially ruin or even break up my family at a time when being together for mutual emotional support will be more important than at any time in their lives.

A family on welfare is entitled to a professional homemaker as well as medical care. And this is as it should be. If we don't help those who have a real need, then we are not the people of a great country. Naturally, the wealthy can afford needed services. I think that is debatable now, too.

It is the middle- and low-income, self-sustaining families who have difficult and painful decisions to make because money becomes the major influence in deciding what has to be done. Meeting physical and psychological needs of a family no longer is pre-eminent. Children may be moved around or casually taken care of and certainly not consulted during a time of high emotional tension when security and love are needed more than ever.

I cannot overemphasize the importance of adding, as part of a national health bill, funding to support a professional homemaker service. I do not ask for this aid lightly. After months of personal association with different solutions to aid my husband in the care of the children while I was in the hospital, the professional homemaker appears best to answer the needs of a family. However, I will first discuss the other possible solutions a family can consider.

My husband and I are very lucky. Both sets of our parents are alive and vigorous. Each time I was hospitalized, one or the other set of parents took over the household. In a two-story house, taking care of two children—3 and 6 years old—would exhaust the grandparents in 1½ weeks. I think you are not surprised. Despite the cooperative, wonderful children I have, it is very fatiguing to do the things young women do. In fact, ask any young woman with young children and she will tell you she is tired at the end of the day. So grandparents should do their duty—love and spoil the grandchildren—but not raise them and run their home.

Few families believe that living in an expanded family is the best way to live. A maiden aunt or grandparents living with the nuclear family are only two examples of an expanded family situation.

In addition, today we live in a mobile society. Families no longer live in the same neighborhood. Care and help is more difficult to get from family members.

Another attempted solution is making use of volunteers who will come into the home to take care of the children and the incapacitated mother if she is at home. In my town, there was an ill mother with three children whose friends tried to help. When I spoke to one of the volunteers (incidentally, a nurse) she felt that the situation created by the different volunteers made life for the family worse. As their friend became sicker and came to the end of her life, the women felt sorry for the children and did things for them that created problems for the father when he came home from work. Instead of helping the children become independent, they allowed them to regress and require more and more care.

Since everyone raises children differently, the five or six volunteers acted toward the children as they would have toward their own. The children had five, six or seven different sets of standards. The confusion, the hurt of a sick mother, the lack of consistent adult behavior put pressures on a 2-, 4-, and 6-year-old and, of course, upon their father.

The major positive result of a volunteer situation certainly is the lack of monetary cost to the family. The love and help shown by friends is also very important but, as the nurse-volunteer said, "It is not the best solution."

All other solutions cost money, whether from the family or the State or both. Babysitters in Massachusetts cost 75 cents to $1 an hour; a child care center costs $36.75 a week for a family of four with an income of $15,000 a year, foster home care costs between $24 and $42 a week depending on the age of the child; maids cost approximately $100 a week; college students who get room and board cost $20 to $50 a week; and, finally, professional homemakers cost $4.50 an hour or $200 a week. Add to these expenses the possibility that the sick mother will have to be in an acute care hospital or rehabilitation hospital at an average of $100 a day and at some point, it becomes clear that the family will be financially unable to pay for food, shelter, or clothing. Then, they turn to welfare. So the State will end up paying for everything anyway.

The issues are how to keep a family together, not take every last bit of money, and keep a healthy emotional home life when death becomes part of the lives of the individuals. The homemaker and home health aid service seem to me to answer this need.

Of all the people trained to work with children and adults, the professional homemaker is one especially trained to give the necessary emotional support during a very difficult time. In fact, the homemaker gets more training to be a mother than a natural mother does. Nutrition, running a house, helping with rehabilitation exercises and aiding the elderly as well as the young are all part of the training a homemaker receives.

At least 300,000 more professional homemakers are needed in this country. So we come to an important aspect of adding homemaker service to a national health bill. People need jobs. Here is a way to lower unemployment. Not only will homemakers get jobs, but teachers, caseworkers, social workers, home economists and directors will have a place in the work force. This is one area along with nurses, doctors, paramedics and home health aides, where the need for these people never ends. Since the health industry will always exist and always need workers, this expanded portion of the labor force will be recessionproof. As I understand it, the economy gets in trouble when people are out of jobs and can't spend money. Let's help people by giving them jobs and let's help people who need help.

It is understandable that everyone wants to spend as little money as possible when solving health and social service problems. But there are, at this point, very few solutions which do not involve government aid. When serious illness strikes, it turns out that keeping a family together with a homemaker is less expensive than hospitalizing the mother if the homemaker can take care of her. Adding families to welfare because they have spent all their money for child care during a mother's illness certainly does not bring social service costs down.

In conclusion, the national health bill without homemaker service will be a cruel hoax and a delusion for families and mothers who are disabled for the long term. For those families, the costs of an indispensible homemaker will wipe them out financially as surely and as effectively as a so-called catastrophic illness does today.

Mr. ROSTENKOWSKI. Thank you, Mrs. Howard.

Mrs. HOWARD. Thank you.

Behind my speech is a fact sheet. It is in pink, which isn't so attractive, but it gives a history and tells you what a homemaker does, and I think just because it is a fact sheet, and not a written out thing, it will help you. I do not represent the national council, but I felt their information was the best, and one other thing, they have national standards for homemakers, and we don't want to get into this business of a mess.

I thank you very much. This concludes my statement, Mr. Chairman. Thank you for your attention.

Mr. ROSTENKOWSKI. Without objection, the National Council for Homemakers' supplement will be included in the record.

[The supplement follows:]

NATIONAL COUNCIL FOR HOMEMAKER-HOME HEALTH AIDE SERVICES, INC.,
New York, N.Y.

FACT SHEET ON HOMEMAKER-HOME HEALTH AIDE SERVICE

I. THE SERVICE

A. What it is

An in-home service in which a mature, trained, supervised person works in the home and functions as a member of a team of professional and allied workers providing health and/or social services.

An essential community service based on the principle that the solidarity of the family is important to society.

A service given under the auspices of a public, voluntary or proprietary health or welfare agency to help preserve, improve or create wholesome family living and prevent family breakdown.

B. When it is needed

When the mother of the family is ill or incapacitated.

When aging or handicapped individuals need personal care and assistance with domestic routines to maintain themselves in their own homes.

When a hospital stay can be averted or shortened by provision of adequate in-home services.

When children or aged persons are neglected or abused.

C. How it helps the family

Prevents break-up of home and uprooting of children.

Frees breadwinner of household to pursue his work and older children to attend school.

Enables many chronically ill, disabled and aging persons to remain in their own homes.

Shows families how to raise their standard of living.

D. How it benefits the community

Extends and augments essential community health and welfare services.

Frees more hospital beds for acutely ill.

Eliminates psychological and financial costs of unnecessary institutional care.

Decreases demand for custodial facilities.

Provides employment for thousands of educationally disadvantaged capable men and women.

E. Who pays for it

Family is charged a fee based on ability to pay.

Cost is sometimes paid through government or private (nonprofit and commercial) health insurance plans—Medicare, Medicaid, Blue Cross Association or private insurance companies.

Cost may be paid through public welfare funds for those in receipt of public assistance.

F. Where requests for it originate

Family.
Physician.
Nurse or Social Worker.
Friend or Neighbor.
School.
Hospital.

II. HOW IT BEGAN

In 1923 first service established in Philadelphia by Jewish Welfare Society.

In 1937 first national conference on "supervised housekeeper service" sponsored by U.S. Children's Bureau—this led to formation of National Committee on Homemaker Service.

In 1962 the National Council for Homemaker Services was incorporated and in 1971 the Council changed its name to National Council for Homemaker-Home Health Aide Services, Inc., to symbolize that it is one service equally useful in the health and social service fields.

How it has grown

In 1963—300 homemaker-home health aide service programs were in operation in 44 states.

Today—approximately 1,800 such programs are operating in 50 states and in Puerto Rico.

There are fewer than 45,000 homemaker-home health aides in the U.S.; more than 300,000 are needed.

III. THE HOMEMAKER-HOME HEALTH AIDE

A. Who she is

A mature, trained, professionally supervised woman (or sometimes a man).

A woman who likes people; trained in care of children, the aged and chronically ill; home management; accident prevention; and safety tn the home.

A staff member of a health or welfare agency which is responsible for her recruitment, training and supervision. (Training is usually conducted by the agency employing the aide.)

B. What she does

Cares for children, the handicapped, the ill or elderly.

Plans and prepares nutritious meals within family budget.

Does marketing.

Does light housekeeping.

Carries out instructions concerning personal care under appropriate professional supervision.

Encourages family, in some instances, to become better organized and to attain higher living standards.

IV. THE NATIONAL COUNCIL FOR HOMEMAKER-HOME HEALTH AIDE SERVICES, INC.

A. What it does for the field

Promotes understanding of values of the service.

Provides a central source of information.

Encourages and guides communities in organizing and extending programs.

Promotes standards for the service.

Provides approvad (accreditation) program to help assure agencis are meeting basic standards.

Publishes reports and distributes educational and promotional materials.

Sponsors conferences and seminars.

Presents testimony before appropriate Congressional committees.

B. Who is eligible for membership

Agencies providing homemaker-home health aide services in accordance with the standards of the National Council.

Organizations, corporations and individuals interested in supporting the Council's purposes.

Mr. ROSTENKOWSKI. Mr. Trautman.

Mr. TRAUTMAN. Mr. Chairman, I am Donald Trautman, chairman of the Legislative Committee of the National Association of Home Health Agencies. I, too, am neither a doctor, or nurse.

Mrs. HOWARD. Or a mother.

Mr. TRAUTMAN. Or a mother, but I would like to ask that the homemaker category be added to the health care bill.

Started in 1970, our association membership includes home health agencies, individuals, State associations and national organizations interested in home health care. Our purpose is twofold: (1) to foster high standards of patient care, and (2) to promote methods of financing home health care and encourage the development of quality home health services throughout the Nation.

In order to conform to time constraints, I will limit my remarks this afternoon to the necessity for the development of a comprehensive program for the delivery of long-term care services as an integral and priority part of a national health plan. Inasmuch as I will attempt not to duplicate previous testimony presented to this committee, I urge members and staff to review my association's presentation of May 23, 1974, which is printed in volume 4, "National Health Insurance," hearings before the Committee on Ways and Means, 93d Congress, 2d session, beginning on page 1652; and my statement on September 19, 1975, to this subcommittee concerning the need for improvements in the medicare program.

I am somewhat disappointed, knowing the policy of the committee, that we were not able to have a full panel in attendance today, since I think the dialog would have been of more value to the committee.

At the outset, permit me to emphasize that while I am speaking today about the development of home health services as a central component of a comprehensive long-term care service program, I do not want to deemphasize the role of such services as an essential part of the present acute care system. Home health services provided through the auspices of a multipurpose home health agency can meet a patient's curative, rehabilitative, and maintenance needs: It is the role of home health agencies to provide those services which compensate for those conditions which impair the ability of an individual to function independently at home.

Our association believes it is essential that this committee, in writing a national health insurance plan, reconstruct our health care financing system to match services to patient needs rather than to accept the present practice of ordering patient placement in a specific institution or with a organization.

At the root of present practice are two limiting factors which cause an institutional bias in the health care system and actually retard the provision of needed care to a sizable patient population.

First, both Government and carriers of health insurance accept as given a tightly defined medical model as the promise for defining benefits and payments. It is this carefully defined clinical-treatment system that sets in motion the machinery to justify admission, treatment modalities, utilization, lengths of stay, and monitoring the quality and quantity of care. While this medical model meets the acute, episodic institutional needs of the patient, it overlooks the individual patient's potential to function in the social and family spheres of his life at home. The objective of this care is only to help the patient through the acute crisis as quickly as possible. Success is measured in recovery terms. The services, facilities, and resources needed to attain a recovery are usually finite.

Unfortunately, the medical model cannot be used to describe benefits for chronic illness, geriatrics and long-term care services. The complexity of multiple-diagnoses and chronic illness conditions, combined with social, emotional, economic and other fragilities common to many chronically ill persons, limit the application of a tightly defined clinical-treatment system.

Second, it is the norm under present practice to describe the scope of and eligibility for health care services in terms of levels. The levels of care needed by the users and the level of service provided by classes of providers not only have complicated and limited the provision of patient care, but have also created an administratively cumbersome mechanism for monitoring the quality and quantity of services.

This develops an artificial classification of both patient and providers. Superimposed upon actual patient needs is a rigidly defined benefit structure complete with limitations upon lengths of stay and eligibility for placement. Providers are grouped according to an array of rather complex, lengthy and unwieldy regulations. This erroneously implies that most users have the same needs which require the same sets of services, and, that all providers in a class are alike and have the same capacity to furnish the same sets of services.

Working in tandem, the medical model as the premise for entry into and exit from the health care reimbursement program, and the artificially defined levels of care as the basis for payment and placement, present policy:

1. delays entry into the health system through limitations that prevent early detection and treatment;
2. provides nominal incentives for optimum use of health resources and discourages cost-efficient use of home health service;
3. encourages isolation, inducing an increased dependency upon institutionalization for individuals whose needs are maintenance and rehabilitative rather than curative;
4. sets minimal standards for providers thereby discouraging the provision of quality care or innovative individualized care;
5. overemphasizes quantitative factors such as size of physical facility rather than qualitative results that can be measured through periodic use of a patient functional assessment evaluation instrument; and,
6. neglects the needs of a sizable patient population whose requirement for care does not conform to the artificial structure of the reimbursement system.

Most of the national health proposals being reviewed by this committee do little or nothing to correct the above cited deficiencies. This limits both the scope of services available to those who are not presently being served, and greatly reduces the potential for expanding cost-efficient alternatives to institutional care.

We recommend that serious consideration be given to the Medicare-Long-Term Care Act introduced by Congressman Conable (H.R. 2268) and Congressman Pepper (H.R. 1354). Both of these measures amend the medicare program to provide for the creation of community long-term care centers and State long-term care agencies as part of a new administrative structure for the organization and delivery of long-term care services. Many members of this committee may recall that the provisions of this legislation were an integral part of Comprehensive National Health Plan introduced by Senator Kennedy and Congressman Mills during the 93d Congress.

We cannot underscore the importance of this proposal. It develops a community network for the delivery of long-term care which emphasizes prevention and home health services as primary components of the delivery system.

In many ways the role of the long-term care center set forth in the act parallels the activities which many certified home health agencies have found effective. Our experience underscores the importance of manqdating an initial evaluation and reevaluation mechanism. Unfortunately, the present benefit and reimbursement procedures cause a fractured and disjointed health delivery system at the local level. This procedure discourages detailed evaluation and followthrough by any agency, organization, or staff member.

Clearly, the functions of the community long-term care center would fill an extreme void within our present delivery system. The act requires the centers to: One, provide a full range of services to include home health services, homemaker services, nutritional services, long-term institutional care services, day care and foster care services, and community mental health center outpatient services to each individual eligible who lives within the service center area;

Two, evaluate and certify the long-term care needs of an individual for whom such care may be required with an emphasis on maintaining the recipient in an independent living arrangement;

Three, require the center to help guide a recipient of services through the health delivery system; and

Four, provide full opportunity for an individual and family to participate in the decisions made by third parties related to placement and type care provided.

In many respects, this is the role and function which multipurpose home health agencies attempt to fill in the present structure. We believe, our agencies have proven that when these services are available, patient response is favorable, and cost-efficient decisions have occurred. It is unfortunate that present reimbursement patterns discourage the growth of these services; however, we see the Medicare Long-Term Care Act as corrective of past failures of public policy.

As with any new piece of legislation, there are several deficiencies in the Medicare Long-Term Care Act which we ask this committee to address during consideration of the Conable and Pepper measures.

First, neither measure details the procedures which the community long-term care centers should follow for reimbursement to the providers of services. Our association would urge the refinement of the cost reimbursement mechanism authorized by section 249 of Public Law 92–683—Social Security Amendments of 1972—to include reimbursement for home health agencies as the principal means for payment.

Second, neither measure seriously considers the need for provider standards. Our experiences under medicare and medicaid point to the need for a strong single uniform Federal standard as a prerequisite for participation. There should be a section in the legislation which requires Federal certification and State licensure of providers as a condition of provider agreements entered into by the long-term care center. These standards should address quality of care, performance, disclosure of ownership, and conflicts of interest. For more details, please review our September 19 statement to this committee on medicare.

Third, we urge a careful review of the definitions in the legislation as they tend to limit the scope of benefits and the services of providers of care. For instance, both measures before the committee co-opt the definition of home health services written into section 1861(m) of the medicare program. Many of the amendments to this section—1861(m)—incorporated in the National Home Health Care Act of 1975 should be considered by the committee in the discussion of the Medicare Long-Term Care Act.

Fourth, while the legislation attempts to broaden the provision of care, there are limitations on the eligibility for certain services such as nutrition and homemaker services which we question. Our association believes that as long as the services are determined as necessary by the community long-term care center, provided by a certified home health agency and certified by a physician as proper treatment, that additional administrative limitations are unnecessary.

We look forward to the opportunity of working with this committee in perfecting the medicare long-term care program as a workable program that will expand the scope and quality of health services.

In the few remaining minutes, I wish to briefly review the policy statement on health care which our association adopted following 2½ years of careful study. These are submitted for the record in our prepared statement and we feel they are important elements of home health services. There are four points.

[The information follows:]

1. The scope of benefits should be limited only by the requirement of medically necessary. Restrictions on prior hospitalization, cost sharing, number of visits and level of care seriously distort the responsiveness of the health care system, and clearly limit home health care as a first line defense in the health delivery system;

2. There is a need for high quality uniform Federal standards that require full compliance for qualifying providers in all Federal health care programs. Without national guidelines prescribing certain quality of care, performance and ownership requirements, many faults of the present delivery system may be repeated.

3. A full range of home health services including nursing, physical therapy, occupational therapy, medical-social work, nutrition, speech therapy, podiatry, homemaker-home health aide, drugs, biological supplies, appliances, equipment, diagnostic and therapeutic items or services and other related services necessary to provide for the health and safety of the patient should be provided on a part-time or intermittent visiting basis under a plan of care collaboratively established and periodically approved by the responsible physician.

4. A home health agency must meet stringent performance standards that require that: it be engaged in providing the above cited services; have a governing body that is readily identifiable and held accountable for the management of the agency; have established policies which are periodically reviewed and approved by a committee of health professionals; provide therapeutic services through agency staff under the supervision of appropriate professional health care personnel; maintain appropriate clinical records; have established policies and procedures for ongoing systematic evaluation and revision of the total program, including utilization review; have a planned program of orientation and inservice education for all employees including all contractual personnel; and have a viable reciprocal arrangement for timely transfer of patients' information with other care providers.

Mr. TRAUTMAN. In that context, the National Association of Home Health Agencies supports the elimination of prior hospitalization requirements for home health services, the concept of a prospective payment system which provides incentives for quality management payments and the development of comprehensive and uniform Federal benefits replacing medicaid. We oppose legislation that establishes standards for certification of providers, which are inconsistent with the uniform Federal standard; reduction of the current home health service benefits under medicare—including visits, deductibles, and coinsurance; the current medicare skilled nursing limitation; prior hospitalization requirements; the requirements that an individual needs skilled nursing care or physical or speech therapy as a primary service to receive before payment for home health services; and limits on home health and outpatient services while providing unlimited hospital benefits. We feel his could be of catastrophic cost to the family, and you would not include them in the health care provisions.

It should be obvious to the members of this committee that in reviewing the standards which we have set as our goal in national health insurance, that here is a necessity to develop the medicare long-term care program as an integral component of the national health bill developed by this committee.

Thank you for permitting us to present our views on long-term care and national health insurance.

Mr. ROSTENKOWSKI. Mrs. Howard, would you like to make other observations?

Mrs. HOWARD. I could say a lot.

One thing that has hit me is that I hope that when decisions are made, that we don't have more bureaucracy. I don't think I have to explain it.

The other thing is that I realize money becomes a very important product in this situation. I know how I run my house, and I know that if I go over the budget, I am in trouble. It means we don't eat the following week, or maybe the roof over the head goes or something.

Mr. ROSTENKOWSKI. You don't have the privilege of going out and printing more money, do you?

Mrs. HOWARD. No. I couldn't even get a job.

Mr. ROSTENKOWSKI. Unfortunately, this Government does.

Mrs. HOWARD. That is true, but it makes it a little difficult when you print money.

Money in the overall big government could be spread around a little bit better.

For instance, I heard a national news reporter on national TV say that $13 million was being spent around the world on golf courses for military officers.

Now, $13 million would do a nice job to help get homemakers, for instance.

So where are we putting money? I am saying let's keep things in perspective. Let's examine our priorities and assess what this country needs—to help people whether they are sick or whether they are in need of jobs. I will leave it at that.

Mr. ROSTENKOWSKI. Thank you.

Mr. Trautman?

Mr. TRAUTMAN. I think the one thing you have to keep in mind as you draft legislation is that you actively involve the recipient in any decisionmaking process. This is probably the most important element of long-term care.

It is amazing how these people provide a lot of practical solutions to a lot of complicated problems developed by professionals. I really am concerned that in this process we lose sight of practicality. One of the advantages that home health agencies have is in the way this committee structured the 1966 medicare, home health provisions. This structure provides feedback for some very practical solutions that could and hopefully would be used to help encourage the professionals to consider more and more the input of the people they are trying to serve.

Mr. ROSTENKOWSKI. I think that in the testimony, and in the panel discussions that we have had, this has certainly been highlighted. I think that the most impressive observations that are made on this subcommittee are about the amount of redtape that is involved in everything that Government does. I think this is one of the areas on which we will spend a lot of time.

I don't have any further questions. I want to thank you for participating this afternoon in our discussion.

The subcommittee stands adjourned until 8 o'clock tomorrow morning.

[Whereupon at 2:40 p.m., the hearing was adjourned, to reconvene at 8 a.m., Thursday, November 20, 1975.]

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